

THE **CANADIAN HOSPITAL**

**OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL**

OCTOBER, 1950

Congratulations to Ohio Valley General Hospital

STEUBENVILLE, OHIO

On its Efficient, Modern-Equipped Laundry Department

PROBLEM—Linen inventory required at this 214-bed hospital was large and costly. Yet shortages in clean linens continued to hamper hospital functioning.

SOLUTION—The problem was placed in the hands of our Laundry Advisor, who made a careful survey. His report recommended new, high-speed equipment specifically adapted to hospital's needs, and listed benefits and savings it would accomplish. Detailed plans were approved and the efficient, modern laundry installed.

RESULTS—Linens and uniforms are returned to service on exceptionally fast schedule. Linen inventory has been reduced, effecting large savings. Yet laundry easily maintains abundant supply of sterile-clean linens in all departments of hospital. Management is pleased with excellent quality of work produced and low laundering costs.

Large or small, your hospital can obtain the free services of our Laundry Advisor. WRITE today.

Your hospital will benefit by selecting from our complete line of most advanced and productive hospital laundry equipment.



▲ At Ohio Valley General Hospital, linens are speedily washed sterile-clean in 2 CASCADE Washers, left. Excess water is removed in Monel metal O. T. Extractor, right.



▲ High-production 6-Roll SYLON Flatwork Ironer beautifully irons linens at amazing speeds.

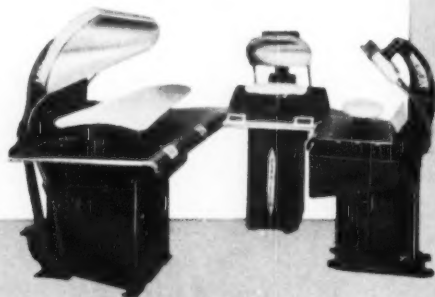


▲ Linens requiring no ironing are fluff-dried in 2 ZONE-AIR Tumblers, left. NURSES' UNIFORM Press Unit is at right.

Ohio Valley General Hospital's efficient NURSES' UNIFORM Press Unit, consisting of 3 carefully designed presses which completely machine-iron uniforms with no hand finishing required. Only one operator irons uniforms attractively at high speed. Pressing surfaces accurately fit all portions of uniforms, imparting trim, neatly ironed appearance with minimum operator motions.

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Remember . . . Every department of the hospital depends on the laundry.

The CANADIAN HOSPITAL



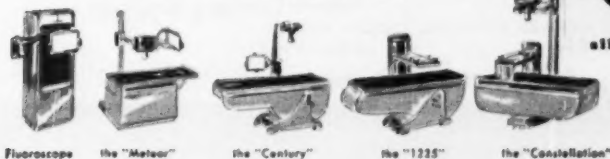
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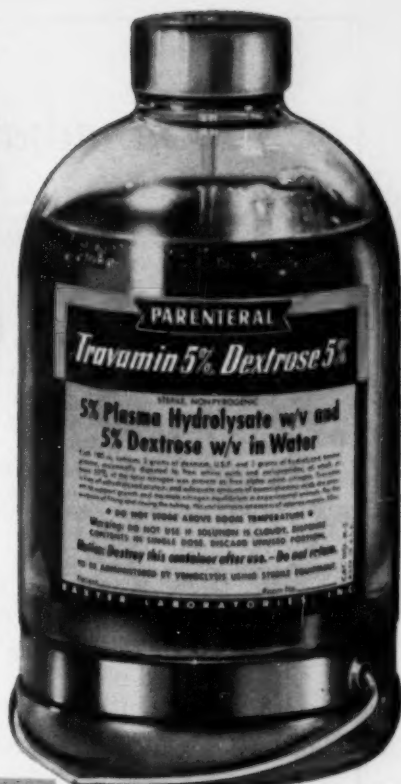
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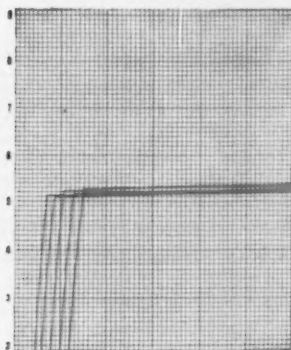
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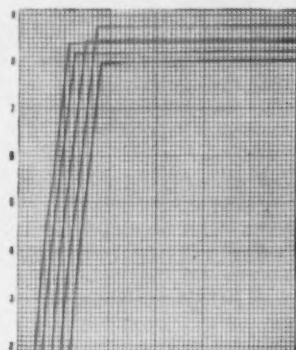
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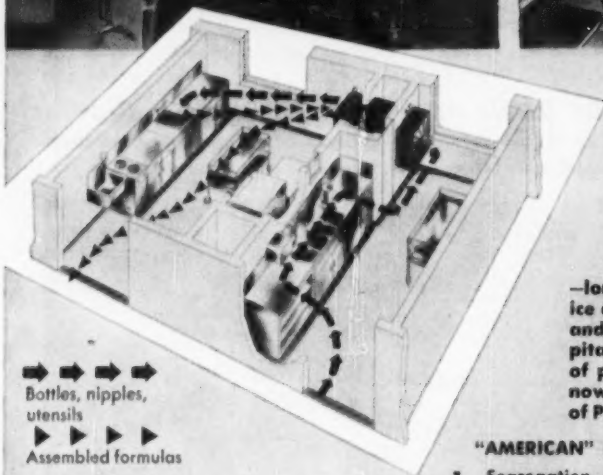
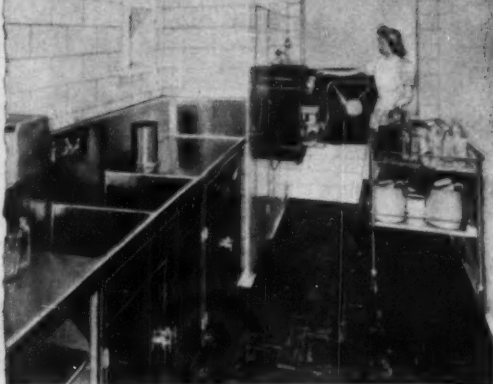
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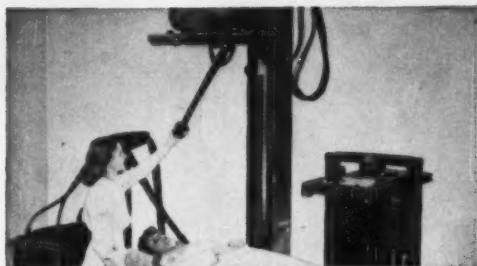
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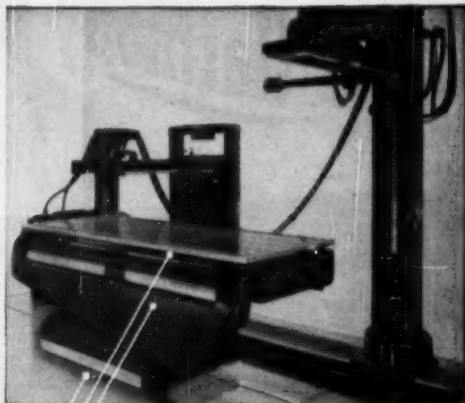
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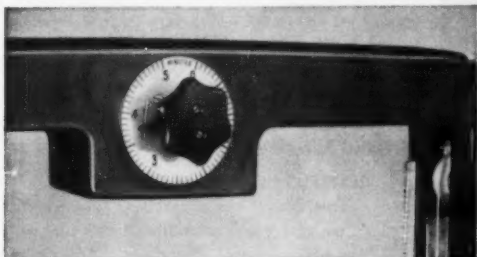
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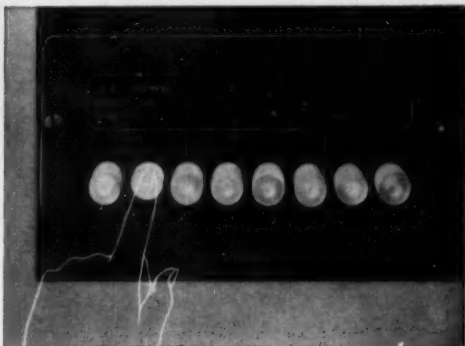
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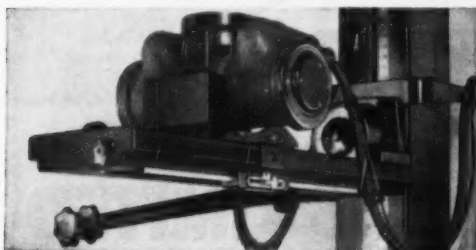
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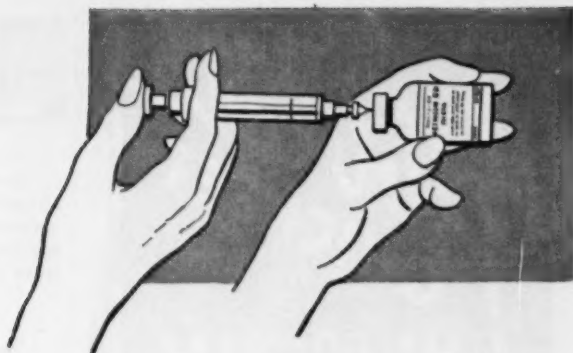
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manipulation and instrumentation and to center the field of vision when used alone as viewing tubes, are some of the features of the unit. Breath deflecting mechanisms are attachable to each of the tubes to deflect air from the lung and prevent fogging of the operator's glasses. Further information is available from American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York City.

* * * * *

Troy Laundry Machinery Now Sold by McKague

The McKague Chemical Company Limited, Toronto, manufacturers of the complete line of McKemco laundry detergents, have been appointed exclusive Ontario sales representatives for Troy Laundry Machinery. The sales engineering and service personnel of the company operating in Ontario have been added to their staff.

The Troy line is one of the foremost in the United States and includes washing machines, ironers, presses, and extractors, many of which are giving satisfactory service in Canadian commercial and hospital laundries. This new sales set-up will also result in better maintenance, for the experience of McKemco laundry experts will be available to service and repair all types of equipment.

* * * * *

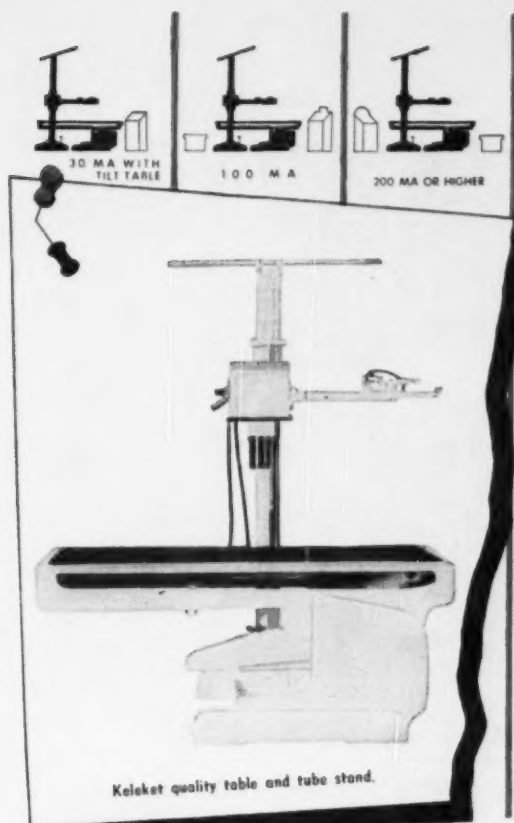
Hobart Opens New Peterborough Showrooms

The new showrooms and service department recently opened by The Hobart Manufacturing Company Limited, at 384 Water Street, in Peterborough, brings to the hospitals, food stores, bakeries, hotels, restaurants and institutions of Eastern Ontario, fast efficient servicing of "the complete Hobart line".

In charge of the Peterborough operation is George O. Orr, well known to Eastern Ontario business men. The new Hobart showroom will carry a representative line of Hobart equipment on display at all times.

(Continued on page 16)

The CANADIAN HOSPITAL



**Fits your
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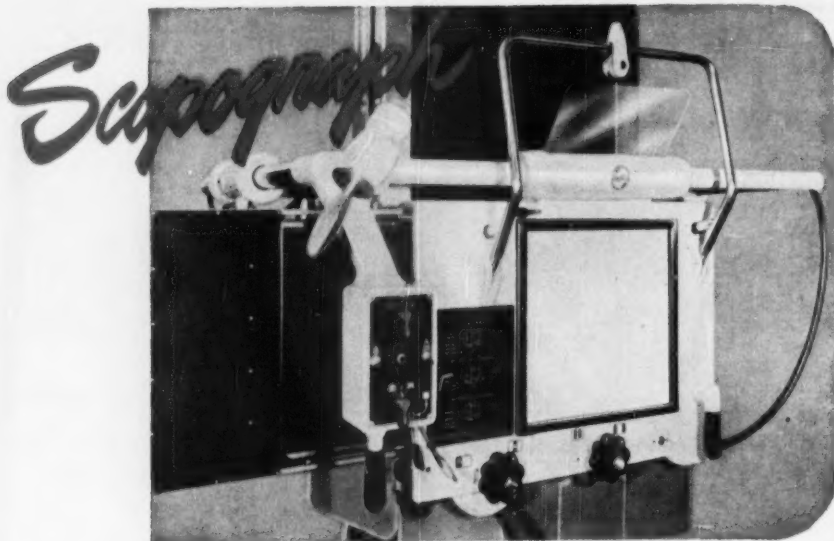
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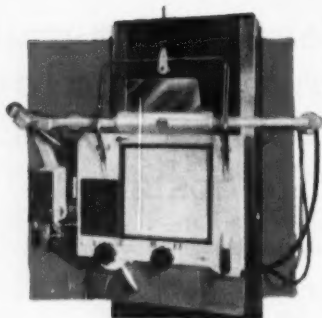
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Now available with the new X-ray detectable insert with **SERRATED EDGES** giving definite configurations and patterns which are more readily detected by the radiologist under difficult conditions.

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Weight 200 lbs.
Height 5' 8"
Thickness of part
x-rayed—29 centimeters

Factors

Milliamperes 100
Kilovolts 75
Distance (centimeters) 90
Time (seconds) 2



The above X-ray photograph was taken experimentally to illustrate the high degree of radiovisibility of RAY-TEC Lap Packs under the most unfavorable radiologic conditions. A pack was extended along the spinal column as indicated by the upper arrow in the photograph, and another pack was tightly rolled up behind the pelvis as indicated by the lower arrow.

The new serrated edge is clearly visible. The monofilament in RAY-TEC Lap Packs has a concentration of Barium Sulphate, U. S. P., which is non-toxic. Made with four thicknesses of gauze (cross stitched), and looped tapes, RAY-TEC Lap Packs will stand repeated launderings without losing their shape. Available in four sizes (100 to a case): 12" x 12", 18" x 18", 18" x 4", and 36" x 8".

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A New Curarising Agent

Eulissin is a sterile solution of decamethonium iodide. Decamethonium iodide has much less activity in liberating histamine or heparin and further it paralyses the autonomic ganglia to a lesser extent than d-tubocurarine chloride. It causes a paralysis which reaches its maximum in about four minutes, recovery beginning after about ten minutes and being complete in one to two hours.

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Eulissin is available in ampoules of 2.5 c.c., each containing 5 mg. of decamethonium iodide, in boxes of 6, 12, and 100 ampoules.

Complete literature supplied on request.

THE ALLEN AND HANBURY'S COMPANY LIMITED
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Across the Desk

(Continued from page 12)

With Alexander Murray Company

Alexander Murray & Company Limited announce



the appointment of Robert G. Rogers as general sales manager, with headquarters in Montreal. Mr. Rogers has had wide experience in the building materials field in both sales and executive capacities, as well as in practical engineering and construction. He studied engineering at the University of Toronto and during the war served for five years in the Armoured Corps as a Major in the 1st Hussars.

* * * *

Wall Chemicals Now Imperial Oxygen Limited

Mr. R. C. Holbrook, President of Wall Chemicals Canadian Corporation Limited, has announced that effective October 1, 1950, the company will be known as Imperial Oxygen Limited. This change in name does not, in any way, affect the ownership, management or personnel of the company.

Under the new name "Imperial Oxygen Limited", the company will continue to operate as a Canadian division of The Liquid Carbonic Corporation. The Head Office will remain at 8400 Decarie Boulevard, Montreal, with branch offices in Toronto and Windsor. Distributors are located from coast to coast.

In addition to supplying hospitals with Oxygen and Oxygen Therapy equipment, the company supplies Oxygen, Acetylene and other compressed gases, as well as a complete line of "Gasweld" equipment for Oxy-Acetylene welding and cutting.

* * * *

Westaway Water Softeners

An interesting folder has been issued by the W. J. Westaway Co. Limited, Hamilton, Ont., in which their various types of water conditioning equipment are described. Westaway industrial water softeners eliminate hardness and iron, and assure a uniform supply of softened water. In many ways, they cut costs of industrial processes and services. In hospitals, for instance, the manufacturers state that their softeners save from 40% to 60% in soap and chemical costs. Fabrics last longer and colours stay bright when laundered in softened water.

(Concluded on page 20)

4 reasons why...

New

Terrabon*

Brand of TERRAMYCIN ELIXIR

builds Rx volume



1 UNIQUE POTENCY

TERRABON provides the only broad-spectrum antibiotic available as an elixir. Since 1 teaspoonful (5 cc.) supplies the equivalent of one 250 mg. capsule, *therapy with Terrabon does not require new and unwieldy dosage schedules.*

2 PATIENT APPEAL

attractive cherry color—pleasing mint flavor encourages patient cooperation.

3 BROAD MARKET

for pediatric and geriatric patients, and those patients who prefer or require liquid forms of oral medication.

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TERRABON—supplied as a combination package consisting of:

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250 mg., bottles of 16 and 100;
100 mg., bottles of 25 and 100;
50 mg., bottles of 25 and 100.

*Trade Mark

Order from your wholesaler
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Frigidaire Refrigeration protects freshness of perishable foods

at Hotel Dieu Hospital, Sherbrooke, Quebec

"We have been using Frigidaire equipment since the hospital was built, in 1943," writes Mr. Lucien Hébert of Hotel Dieu, Sherbrooke, Quebec. "At all times we have been entirely satisfied with its performance." The Frigidaire equipment at Hotel Dieu was sold and installed by H. C. Wilson & Sons Ltd., Sherbrooke.



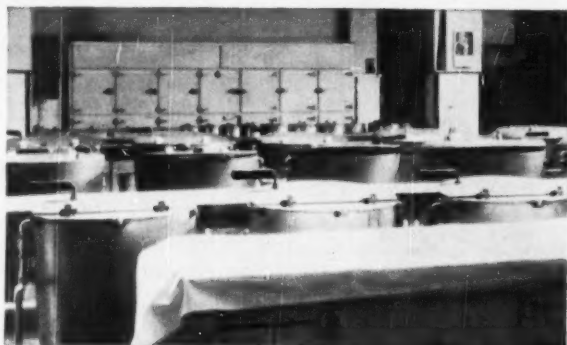
Section of the main kitchen at Hotel Dieu, Sherbrooke, Quebec. There are walk-in coolers for meats, vegetables and dairy products, a 160 cubic feet reach-in refrigerator with fourteen doors, and, in addition, twelve household refrigerators in the various floor kitchens.

In thousands of hospitals, institutions and other buildings, Frigidaire equipment is earning appreciation of its performance in all manner of refrigeration tasks.

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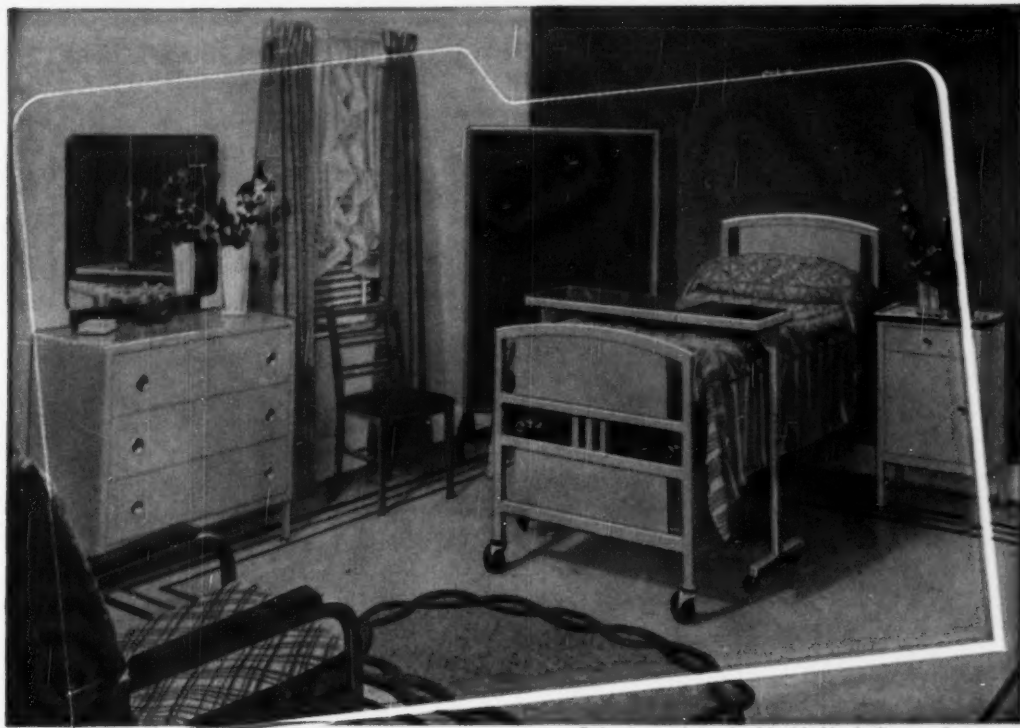
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* * * *

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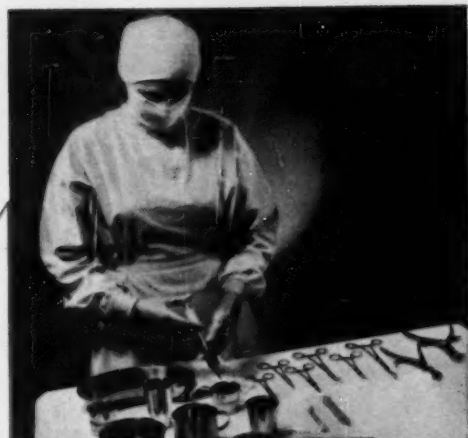
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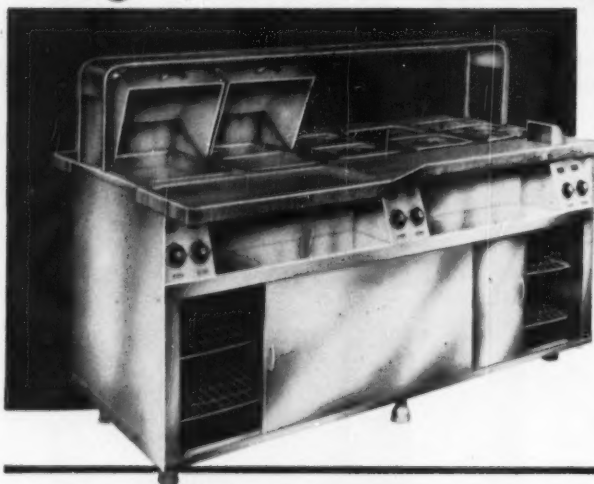
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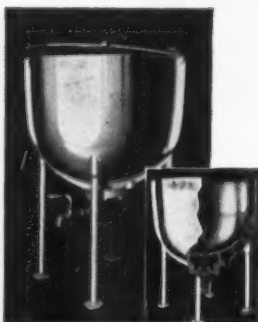
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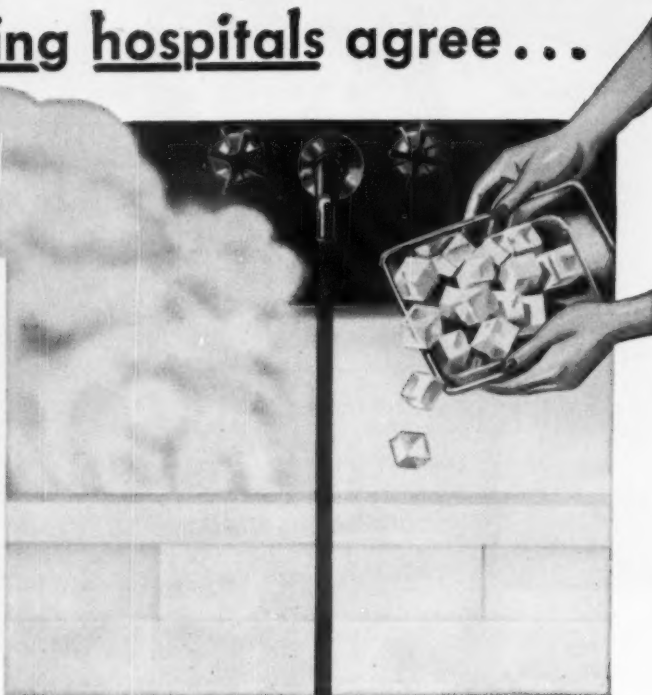
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Leonard O. Bradley, M.D., Editor

Toronto, October, 1950

Vol. 27

CANADIAN
HOSPITAL

No. 10

Obiter Dicta

A National Risk

THE voice of the hospitals of Canada cannot and will not accept the risk of remaining silent until concrete constructive steps are under way to ease the steadily growing shortage of nurses. When this has been accomplished by the joint action of the voluntary schools of nursing and government at all levels, we shall drop our anxious tone for one of commendation and huzzahs. Right now one cannot be other than very gloomy about the whole situation, for there are but few bright spots.

Government is enlarging our defence forces and has organized a United Nations force. We want to see to it that these services will have adequate nursing care if and when combat ensues—is it going to be too little and too late?

We heartily agree with Charlotte Whitton (in the *Ottawa Citizen*) on the great value of the "risk capital" that voluntary foundations can supply to initiate, to experiment, and on some occasions to venture where there seems to be no apparent chance of a successful conclusion. What is hard to understand is that the government considers any money spent for nursing education a risk. Rather is the contrary true.

The limiting lack of financial support for the education of nurses is the most serious risk ever taken by the upper levels of government. They have played the odds for a long time and have won—from a dollar point of view. But hospitals and both voluntary and governmental public health agencies and other institutions that need more nurses are losing steadily every day.

Let us look still further. The risk, inevitably, must be relegated to the point where nursing care is given—to

the patient. The provincial and federal governments are standing by, letting the patient carry the risk. How long can these upper levels of government afford to let the patient carry the risk?



Vital Services

WE are thankful to be able to report to the nation that patients did not suffer or lack for good hospital service because of the recent withdrawal of railroad transportation. We feel that the nation owes to its hospitals a debt of gratitude for the precautions taken to meet this emergency. Our survey (page 46) shows remarkably few dislocations in service and only a few alarming and harmful incidents.

The hospitals in turn owe a debt to truckers, private motorists, and other transportation agencies, on the water and in the air, for filling the breach. Their prompt response made possible an uninterrupted hospital service. For their concern about our patients we say thank you sincerely.

There are few vital services that a country cannot do without—for a short time. There are no vital services that a country should have to do without—at any time. A vital community service should only be withdrawn if the action is necessary to safeguard the existence of the whole populace; under no circumstances can it be tolerated to satisfy the self-interest of a small segment at the expense of the well-being and safety of the whole community.

This is particularly true of all who work in vital ser-

vices for them, more than those in any other means of livelihood or enterprise, have a reasonable measure of employment security through depression and boom, and depression and boom again. They are given this security because their services are vital to the community. And yet the community was repaid by this recent intransigence.

Hospital people, also working in a vital service, have too, a reasonable security of employment, for the sick will be with us for some time to come. The reward to hospital people over the years has been penurious in comparison with the returns to those in other vital services. Yet, throughout the years, there has never been an occasion when hospitals have withdrawn their services from the community.

It must be admitted that in a few isolated instances small segments of the hospital family have not seen their duty clearly, but there may have been some justification when wage and living conditions were compared to those in other fields. On no recorded occasion has it been necessary to refuse admission to those in need. This remarkable history can be attributed to the "service attitude" that attracts people to employment in hospitals and which over the years grows to pervade every thought and action. It is a priceless intangible that must never be sacrificed or lost.

Is there any hope that the community may ever expect it from other vital services of the nation? Is it too much to expect of all these vital services that they make a solemn public pledge that the nation will not again be crippled and hurt because of their own self-interest?

Hospital people across the Dominion from the humblest servant to the most illustrious board member are ready to do so. Have those in the other services sufficient concern for the well-being of the country to make a similar pledge? Would it not be an unusual distinction for Canada, with its democratic traditions, to begin the New Year with a record of pledges from all of its vital services to the effect that no domestic issue shall occasion any break in the solid front presented to the world? In this era of international chaos, a national solidarity based on the spirit of truest brotherhood may well be the *sine qua non* of our survival as a democratic nation.



Face Value

THAT a completely unqualified person should be able to practice medicine in hospitals for five years is difficult to credit. Yet recently such an impostor was discovered. This man, who picked up his medical knowledge while a private in the United States Medical Corps, practised as a staff physician in New York, Connecticut, and New Jersey hospitals. According to newspaper reports he was able to satisfy his nursing and medical associates of his competence, as well as his hospital employers. It was said that there were no errors of commission; we wonder if the errors of omission—incomplete investigation, inaccurate diagnosis, and in-

appropriate treatment—might not have been more serious.

To this incident in medical practice can be added many cases of misrepresentation by so-called registered nurses. Not a few who have been disqualified for drug addiction have found employment in some uncontrolled set-up; others who are without qualifications have taken posts of responsibility.

The shortage of interns, residents, house physicians, and nurses, gives a real advantage to the artist of such chicanery. And the hospital employer, so anxious to strengthen staff in these categories, may be an easy target for the practised deceiver. Most often, however, it is because the applicant has been accepted at face value.

These incidents occur because the checking of credentials, after a long period of calm, becomes casual and often is forgotten. This is doubly unfortunate in that the provincial colleges of physicians and surgeons, and the nurses' registries in each province are alert to these dangers and are prepared to give information—if they are consulted. Close co-operation with these agencies will protect the employer and, of course, the patient.



And Now—Drive-In Hospital Care

SOME of you will have read the *Architectural Record* of August, 1950, with its featuring of "Drive-Ins".

This service principle is being carried out in "motels, restaurants, theatres, banks, shopping centres and even a church", that the automobile conscious and dependent public may be offered a special service and attraction.

For the record, hospitals have been using this wrinkle in different ways for many years, e.g., in out-patient departments. Actually, it is difficult to envisage hospital service becoming true curb service, though modern diagnosis and therapy sometimes make one wonder. There is an application, however, that warrants careful consideration—one which is pertinent today, with so many hospitals drawing plans for ambulatory or out-patient service.

The introduction of the *day-hospital* is a variation that may well bring some relief to the high cost of hospitalization and at the same time give each patient the advantage of all of the resources of the community hospital.

Arrangements for admission would be made by the family physician, in the same way as for round-the-clock hospitalization. The physician-in-charge would send along orders for diagnostic and therapeutic procedures. The patient is brought in each morning, at the time when the breadwinner must go to work. The patient could be visited each day by the physician and orders left, in much the same routine as the regular ward rounds. The breadwinner would call for the patient on the way home from work. In the field of psychiatry and in rehabilitation and training of cerebral palsied children, this idea has been tried with success.

Evening and night staff would be practically elimin-

ated in such a department. With the strong pressures on hospital management to conform to community practice in hours and days of work, this might be a partial solution.

Is it a supplement or a complement of a home care program? Might it be a stimulation to the convalescent and rehabilitative program that is so slow in evolving? Could it shorten the length of hospital stay for ortho-

paedic and other types of cases who need only certain specialized treatments? And of greatest importance, could it bring the cost of the service to the patient to a lower level?

The general hospital has made a few small trips into this area. If the present trend continues we'll have more automobiles than homes in this country. Maybe we should "drive-in" with more enthusiasm.

Sharing Laboratory Services —

Travelling pathologist a boon to hospitals in Niagara Peninsula.

THE various hospitals in the Niagara Peninsula are benefiting from an enlarged laboratory service that was inaugurated in July of this year. The growth of this service was certainly not an over-night affair and to give readers an appreciation of the significance of this move, I should like to review briefly the development of laboratory service in this area.

In July, 1941, the Board of Governors of the St. Catharines General Hospital appointed their first full-time pathologist. This was done in co-operation with Dr. A. L. MacNab, then director of laboratories for the Ontario Department of Health. At that time arrangements were made with the hospitals at Welland, Niagara-on-the-Lake, Niagara Falls, and Fort Erie, to send some of the work which had gone previously to the provincial health laboratory to the St. Catharines Hospital. In April, 1942, the hospital entered into an agreement with the Department of Health to do certain public health work for the area and as an aid in this project St. Catharines General received a provincial grant.

For the next few years almost all of the surgical specimens and a few bacteriological and chemical specimens from district hospitals were sent to St. Catharines for analysis.

Lorne Whitaker, B.A., M.D.,
Pathologist,
St. Catharines General Hospital,
St. Catharines, Ont.

In 1949, Ross MacKay, administrator of the Douglas Memorial Hospital in Fort Erie, requested the writer to assume responsibility for running the laboratory in that hospital. It was not then possible to assume this further responsibility since, in addition to laboratory work, there were many medico-legal duties for the pathologist in the counties of Lincoln and Welland. However, for some time the volume of work had indicated that additional help would be necessary and the Board of the St. Catharines General was approached to discuss the advisability of appointing an assistant.

It was felt that, should an assistant be provided and the services of a pathologist be made available to the other hospitals, they should assume some financial responsibility for the salary of the assistant. The next step in the procedure was to invite representatives of the various hospitals to discuss the matter. In March, 1950, a meeting was held with these people and a smaller committee was appointed to draw up definite recommendations. At this preliminary meeting the various

representatives expressed themselves as being in favour of the plan in principle.

Recommended Arrangements

On March 24th, 1950, the committee consisting of Ross MacKay of the Douglas Memorial Hospital, Harry F. Garwood of the Greater Niagara General Hospital, and I, met and discussed the proposal and set down the following recommendations for approval by the various hospital boards.

1. *Duration of Contract.* In view of the fact that an assistant would be engaged on a yearly basis, it was deemed advisable to have the various hospitals review the situation each year before a contract with the assistant would be renewed or a new assistant procured.

2. *Additional Equipment.* It was recommended that development of the service be gradual with no large expenditures for additional equipment to be suggested until the demand for further service warranted new purchasing and until money could be provided through increased income.

3. *Quick Section and Autopsy Service.* This was to be carried on in the usual manner with the exception of travelling expenses. Such expenses were not to be charged since the proposed budget will provide for a travel allowance. In this connection it was felt that the importance of autopsies in maintaining the hospital status cannot be too strongly emphasized.

4. *Surgical Specimens.* The fee

for surgical specimens was to be increased from \$2.00 to \$5.00. As the interpretation of these examinations is part of the work of the pathologist and his salary, under the proposed scheme, was to be supported by a direct contribution from the individual hospitals, the \$2.00 per specimen would still be payable to the St. Catharines Hospital Laboratory while the difference of \$3.00 per specimen would be available to cover, in part, the contribution of the hospitals to the salary of the pathologist.

5. *Medical Staff Meetings.* It was suggested that the pathologist would be available at staff meetings and be willing to participate in the clinical discussions and prepare part of the scientific program.

6. *Blood Bank Service.* The former arrangements in Niagara Falls and Fort Erie were to continue and, in Welland, clinics could be arranged during the time the pathologist would be in attendance at the hospital.

7. *Terms of Contract.* During the first year of operation, the additional budget required to support the assistant pathologist would be apportioned as follows: Welland, 33 1/3 per cent; Niagara Falls, 33 1/3 per cent; Fort Erie, 16 2/3; and Port Colborne, 16 2/3. The Port Colborne contribution was to be assumed by St. Catharines until the new hospital there could be opened. The suggested salary for an assistant was set at \$5,000 with an additional \$1,000 for an expense account.

These recommendations were approved by the various hospitals with the exception of Port Colborne (under construction) and on July 1st, Dr. John F. Booth assumed his duties as assistant to the pathologist.

Time Schedule

Under the present arrangements, the pathologist visits Welland on Monday and Thursday mornings, Niagara Falls on Wednesday and Friday mornings, and Fort Erie on Tuesday morning. This schedule will

of necessity be changed when the services of the pathologist are required at the Port Colborne Hospital. It is hoped that various laboratory procedures will be made uniform and, as time elapses, that new and approved methods will be instituted at the different hospitals.

At the time of writing, it is not possible to say how satisfactory the new arrangements will be. All comments which have been made by medical staffs and administrators have been favourable and everyone seems to be pleased with the new system. Following a six-month trial period, the various hospitals will be invited to review the situation and decide if they wish to renew the contract for a further period of time.

* * * *

Un Résumé

Depuis le mois de juillet 1950, les hôpitaux de la péninsule de Niagara bénéficient d'un service de laboratoire fort amélioré. L'auteur nous résume les différentes phases qui ont précédé cette amélioration. En juillet 1941 le bureau des gouverneurs de l'Hôpital général de St. Catharines mit sous contrat le premier pathologiste à plein temps. En même temps ce laboratoire commença à drainer partiellement l'ouvrage qui allait normalement aux laboratoires provinciaux. En juillet 1942 le gouvernement provincial apporta son aide financière. En 1949 les autorités de l'hôpital de Fort Erie demandèrent à l'auteur de prendre charge des laboratoires de l'endroit tout en gardant son emploi à St. Catharines. L'auteur déclina faute de temps. On organisa alors une réunion des représentants des divers hôpitaux de la péninsule afin de discuter ces problèmes. En mars 1950 à une nouvelle assemblée, on s'entendit sur la durée des contrats, l'emploi des assistants, l'achat de matériel, le service d'autopsie, et sur les différents tarifs. La rémunération du pathologiste et de son assistant fut divisée entre les différents hôpitaux. Le pathologiste se trouve donc à desservir plusieurs hôpitaux. Le système est mis à l'essai pour six mois et alors une nouvelle assemblée décidera si ce plan de travail est satisfaisant.—Yves Prévost, M.D.

Annual Meetings Now in Progress Across Western and Central Canada

As this issue comes from the press, the annual convention of the Saskatchewan Hospital Association has just concluded in Saskatoon. The Western Canadian Institute for Hospital Administrators and Trustees is in progress in Winnipeg, to be followed by the annual meeting of the Manitoba Hospital Association. The conventions of the British Columbia Hospitals' Association and the Associated Hospitals of Alberta follow next week in Vancouver and Calgary respectively.

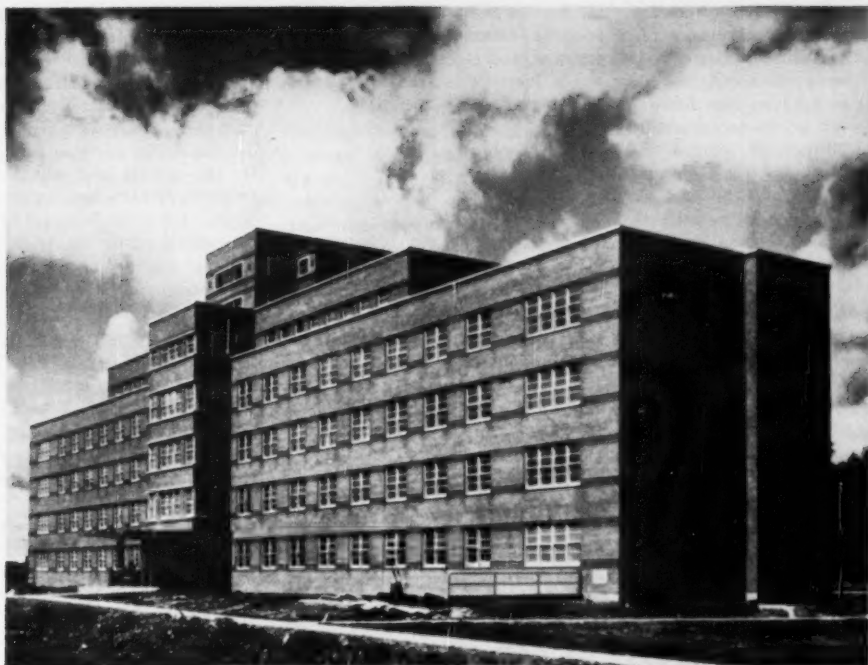
Preceding, following, or in conjunction with these gatherings, will be held the annual meetings of the Regional Conferences of Catholic Hospitals and of the provincial associations of hospital auxiliaries.

Included on the programs of these meetings are many items of vital importance and concern to those engaged in hospital work, to some of which, reference has been made in previous issues. Provincial government activities in health and hospital field disaster preparedness,

construction and equipment, and prepaid care plans are included. The list of speakers bears some resemblance to a "Who's Who" of hospital people in Canada and the United States.

Dr. L. O. Bradley, Executive Secretary, is representing the Canadian Hospital Council at the meetings, as are Dr. O. C. Trainor, Dr. A. C. McGugan, Father H. L. Bertrand, and Percy Ward of the Executive Committee. Miss Jessie Fraser, our Assistant Editor, is also in the west.

The program of the annual meeting of the Ontario Hospital Association was reviewed in September. Although this meeting finishes on November 1st, (nearly two weeks past our official deadline for editorial material) we hope to include some account of it in the November issue. If your copy reaches you a few days late you will understand that it is due to our effort to report these various meetings as fully as possible in this, our convention number.—M. W. R.



Stratford, Ontario, Doubles Its Hospital Facilities

THE opening of Stratford's handsome new general hospital on July 22nd of this year completes the first step towards fulfilment of that community's long-envisioned hospital program. This comprehensive program eventually will provide 170 beds and 56 bassinets for the district in the new building, as well as utilizing the old

The fine new structure shown above is to be essentially an active treatment centre while the earlier building, seen at the right, when renovated, will house chronic patients and isolation cases.



hospital to provide accommodation for the care of 100 chronically ill patients and isolation cases. Thus instead of being discarded, the old building is to have its face lifted—and remain an active contestant in the never-ending battle against disease, as well as solving that very prevalent problem of today, the accommodation of long-term patients. The conversion of the top floor into extra residence space for nurses will help to solve another current problem. Across the street from each other and connected by tunnels, these two buildings should form an excellent unit.

The new hospital, designed by Marani and Morris of Toronto and costing approximately \$1,700,000 complete with furnishings, is equipped initially for 149 beds and 56 bassinets; and until the old building is renovated, the 25 or 30 chronic patients presently under treatment will occupy one wing of the fourth floor.

The patients' rooms are on the first four floors of the hospital. There are 14 four-bed wards, including two wards of cribs, 32 semi-private rooms, including two in the paediatric department, and 29 private rooms divided into classifications of standard, special, and deluxe. The beds are also divided according to the type of case, with 23 for medical, 72 for surgical, 36 for maternity, and 18 for paediatric cases. The bassinets, besides those

for regular maternity cases, include four for premature infants, four for suspects, and eight in the children's wards for infants receiving paediatric treatment.

In this hospital, the bedrooms and other larger rooms are a standard size, 18 feet by 12 feet. This has been done to simplify both construction and installation of plumbing. Thus the same sized room is used for private and semi-private rooms, while the four-bed ward is simply two unpartitioned private rooms. With this arrangement, four-bed wards may be converted into two private or semi-private rooms, or vice versa, merely by the addition or removal of a partition.

Basic furnishings in all rooms are the same, with bedside tables, one chest of drawers per room regardless of size, at least one easy chair, upholstered in foam rubber and slip-covered in sunfast and washable material, and a wooden side chair for each bed. The beds, to allow the use of more comfortable mattresses, are three inches wider than the usual three-foot hospital bed. The deluxe private rooms have an ottoman as well. Except for the deluxe rooms, all furniture is of birch in a natural finish to match the woodwork throughout the hospital. Lighting is provided by gooseneck lamps, attached to the walls, which may be adjusted downwards when required or up towards the ceiling for general lighting purposes. At the head of

each bed is a panel containing electrical outlets for the call switch, radio, et cetera, with a jack for a telephone outlet in private and semi-private rooms. Pastel colourings are used throughout, with bright, cheery designs in the curtains for contrast. In the special and deluxe private rooms gaily patterned wallpaper, lacquered for easy cleaning, brightens the wall opposite the bed, linoleum tile replaces the sheet linoleum used elsewhere, and private bath rooms are provided.

On each of the second, third, and fourth floors is an attractively decorated solarium informally furnished with rattan settees and chairs. There is also a room on each patient floor containing a bathtub which is raised about two feet above the floor for the convenience of both nurse and patient, especially stretcher cases, and a small sitting room for special nurses which contains a call button connected with the central nursing station.

The fifth floor is given over to the pathology department. A referral centre for the district, this department is exceptionally large and well-equipped for a hospital of this size. A large waiting room is provided for patients and near the elevator is the blood-donors' room. Beside the pathologist's office is a small laboratory where he may carry on personal research work.

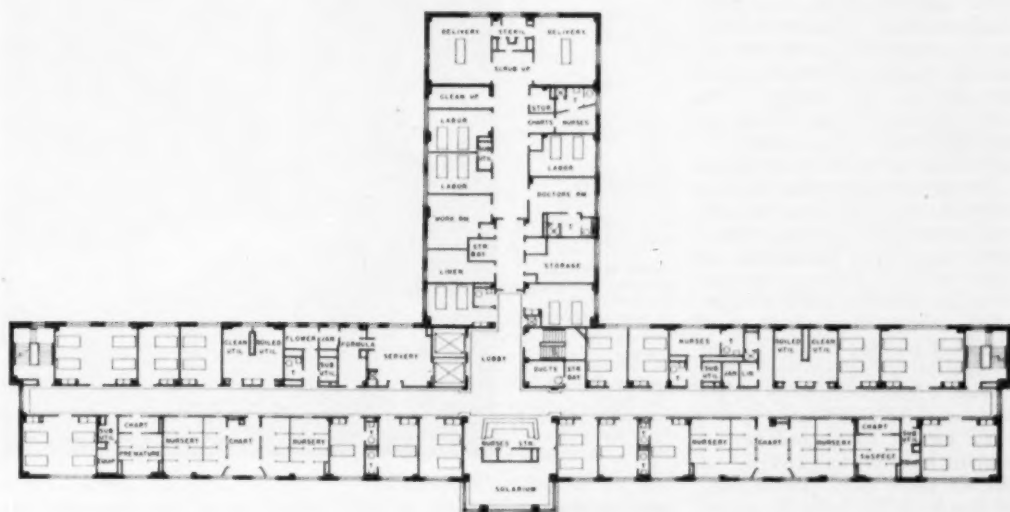
A distinctive feature of the paediatric department, on the fourth



A corner of one of the serveries situated on each patient floor. In the foreground is the electrically heated food conveyor for bringing food from the kitchen.



SECOND FLOOR



THIRD FLOOR

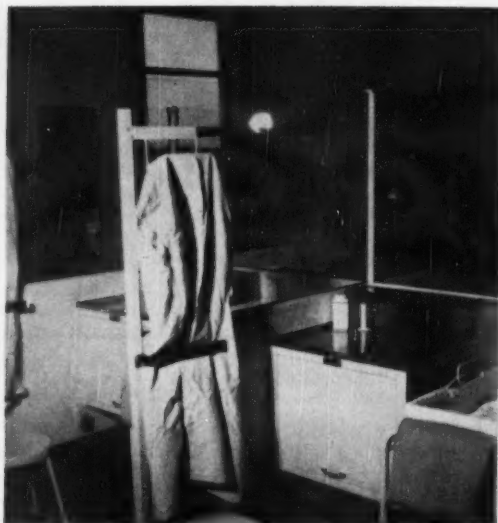
floor, is the use of partitions which are largely of glass between rooms and also between rooms and corridors. Partitions between the beds are of metal and glass screening. In this way, the nurses can see the children, the children can see each other—and the likelihood of impromptu pillow fights is considerably lessened! The "wild west" scenes on the curtains here show cowboys rop-

ing steers from the bouncing backs of bucking bronchos, while a cowgirl watches from atop the old corral fence. Parents of the children are provided with a waiting room in the department.

The nurseries and maternity units occupy the third floor. Each nursery contains 15 glassed-in cubicles complete with individual cabinets. The doctor is allowed to go no farther

than the chart section just inside the door, where the baby is handed through a window in the glass partition to the examining shelf.

The operating wing is located on the second floor. All operating rooms have explosion-proof electrical fittings, including light switches. On one wall is a view-box, used by surgeons to watch x-ray films of the area upon which the operation is



being performed. Near the two major operating rooms is a small laboratory where a section of tissue may be immediately frozen and examined. A small recovery room is also near by. The window in the room for anaesthesia storage is especially constructed to blow out easily in the event of an explosion.

The emergency operating room is located on the first floor, near the x-ray department and the plaster room, where casts are applied. It might be noted, however, that the ambulance entrance, which is an excellent drive-in arrangement in itself, leads into the basement. This necessitates taking stretcher cases through a corridor and up in the elevator to the emergency.

One half of the ground floor is occupied by the administrative offices, the board room, and the medical library. In the radiology department is a waiting room for the public and also private offices for the radiologist and his secretary. In the radiologist's office is a view-box for convenience during consultations.

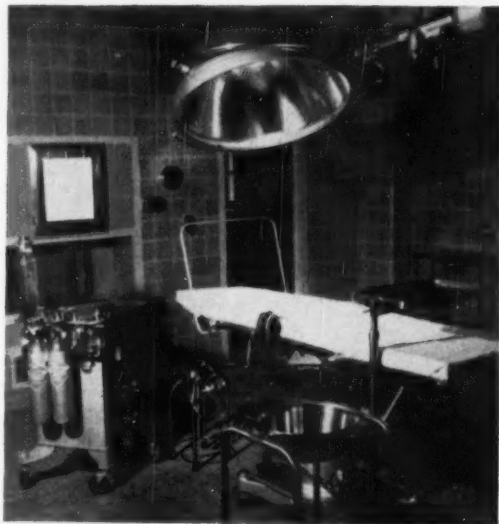
A chapel is also found on this floor where families of seriously ill patients may hold their vigil or seek comfort from their minister.

The use of white, avoided elsewhere in the hospital, effectively highlights the modernity and cleanliness of the large kitchen, which is located in the basement. The walls are tile and wood has been elimin-

Above left: A semi-private room, showing one of the goose-neck lamps.

Above right: The nursery cubicles, each containing its own cabinet and nurses' gown.

Lower: One of the major operating rooms. Note the view-box.



ated wherever possible as a pest control measure. Next to the dietitian's office is the rather small enclosed diet kitchen, and farther down the same side is the main cooking area. The walk-in refrigerators, daily stores refrigerators, and the deep-freezer, are all in one section and controlled by one refrigerator unit. In a room near the ramp leading from the receiving entrance is a small refrigerator for sanitary storing of garbage between collections.

The prepared food is transferred to the serveries on each floor by ele-

vator. One of the hospital's two elevators has a back entrance opening into the serveries and at meal time it is possible to short the automatic control so that it can be reserved entirely for transporting food. Close to the kitchen area are situated the dining rooms, cafeterias and, at the foot of the main stairs, a snack bar operated by the Canadian National Institute for the Blind.

Also situated in the basement is the central supply room. This room is the chief centre for all sterilizing and water distilling in the hospital;

(Concluded on page 112)

Evacuation Peacetime

Experience of one Winnipeg hospital
during the anxious days of the 1950 flood.

MOTHER Nature is a wonderful person. Today, in Winnipeg suburbs such as Wildwood and Riverview or in the towns of southern Manitoba, the casual tourist can find little or no trace of the great Winnipeg Flood of 1950. Lawns are green and houses are freshly painted. Of course, you might notice the odd heap of old plaster, the occasional high-water mark on houses not yet scoured or you may see someone putting in a new basement. If you are lucky, you might even see a team of college boys stalking out the levels for the diking system which the governments have decided, at long last, to throw around the recently flooded areas. Perhaps you would be amazed if you heard some of the remarks being made about these dikes. Four short months after Winnipeg's struggle some citizens can complain that, "It can't happen again. Let's not build ugly dikes, they spoil our view."

However, no matter what precautions are taken for the future—whether dikes be built or the river deepened or a new river channel constructed which would by-pass the city—the past flood and its results will long remain vivid in the memories of many. Among these, most certainly, are the staff and friends of the Children's Hospital.

During the emergency period, many hospitals in the flood area were evacuated through necessity and their patients were sent to different towns and cities. Naturally this caused suffering and, in the cases of some old people, death. The Children's Hospital was also forced to evacuate; it not only moved its patients to a new site but its entire organization as well. Staff, patients, and equipment, were all evacuated on a cold, rainy night, when the building became definitely untenable. With the aid of volunteers, the move was accomplished in an incredibly

Frank H. Silversides,
Assistant Superintendent,
The Children's Hospital,
Winnipeg, Man.

short time. Everything was transferred to the Red Cross Lodge of the D.V.A. Hospital at Deer Lodge and patients were all placed, comfortable and asleep, within two hours after evacuation started. This is a record of which we are justly proud.

Report of the Superintendent

The rest of the story may best be told in the words of Dr. Wallace Grant, the Medical Superintendent of the hospital, in his flood report to the Board of Directors.

"In the early morning of the 6th of May, 1950, the suburb of Wildwood Park and other large areas in the city were flooded, including the Riverview areas. This necessitated evacuation of the King Edward Hospital and many of the patients from the King George Hospital were also removed in the darkness of early morning with water already rising on the streets. The next night, it was feared that the dikes protecting St. Boniface Hospital would not hold and it was evacuated during the night and early morning.

"It seemed wise then, on the 6th of May, 1950, to contemplate the admission of only seriously ill patients to our hospital and to encourage the discharge of all those who might be cared for temporarily at home. The evening before there had been 106 patients in the hospital. By the next morning, with the co-operation of the medical staff, almost twenty patients had been discharged and a further seventeen placed in foster homes.

"At a meeting of hospital superintendents on the morning of May 8th, called at the request of Colonel Morgan-Smith, Commanding Medi-

cal Officer of the Prairie Command, the story of night evacuation from Municipal Hospitals and St. Boniface was told. Plans were formulated to remove patients from St. Boniface Sanatorium, which was completely surrounded by a dike, and from the Nursing Homes along the Assiniboine River. Because of this situation, it was decided that the wise course would be to move our patients to accommodation, which had been arranged the previous day, at the Red Cross Lodge. By this time the number of patients to be moved had been reduced to 53, which included two patients from St. Boniface Hospital who had been transferred because of its evacuation.

"According to plan, members of the medical staff began to arrive by 6.30 p.m., and patients were placed in their cars at the Out-Patient Department entrance. Each child was carried by a nurse, who also had with her the patient's chart and essential medications. In three-quarters of an hour all the children had left the hospital and begun to arrive at Red Cross Lodge. Upwards of 60 cribs and other essential equipment such as food carts, pharmacy refrigerator, stretchers, and bedside tables, were loaded at the east-side porch. All this had to be transported to the lodge within two hours. Apparently most of the children were asleep by 8.30 p.m.

"A dormitory was set up in the auditorium of Linwood School where 25 student nurses could be accommodated and another 19 were berthed in facilities offered by residents of St. James who had homes near Deer Lodge Hospital. Those in the school dormitory slept on beds and mattresses which had been moved from the residence that same evening. So far as I know, all these student nurses, except those on night duty, were in bed and presumably asleep by 11 p.m.

"At the present time, we are operating two hospitals. The Red Cross Lodge Branch is running very smoothly and is already admitting acutely ill patients who require hospital care. The training school will continue to take lectures in rooms provided in Deer Lodge United Church. At the Children's Hospital, the Outpatient's Depart-

(Concluded on page 80)

Atlantic City Scene of A.C.H.A. Annual Meeting and Convocation

THE American College of Hospital Administrators held its 16th annual meeting and convocation ceremony in Atlantic City, September 17th and 18th. More than 200 Nominees were admitted to its ranks; over 100 persons were advanced to membership; and six candidates became Fellows. Canadians admitted or advanced in rank numbered 32. Two Honorary Fellowships were awarded for conspicuous service in the field. The recipients were Haven Emerson, M.D., Professor Emeritus of Public Health Administration, Columbia University, director of health and hospital surveys in many cities of the United States and in Athens, Greece; and Vane M. Hoge, M.D., Assistant Surgeon General, Bureau of Medical Service, U.S. Public Health, and Administrator of the National Hospital Survey and Construction Act.

The impressive convocation ceremony was held on Sunday afternoon. Following the solemn procession, candidates for advancement and admission were presented by Frank J. Walter, President-elect of the College and certificates were conferred by Wilmar M. Allen, M.D., retiring president. At the close of the program there was a reception for newly inducted members who were greeted by officers and regents of the College.

The colourful A.C.H.A. banquet was held Sunday night with the president, Dr. Wilmar M. Allen, presiding. In his presidential message, Dr. Allen stressed the importance of carrying out the College's educational program without delay since well-educated and prepared administrators are more vital than ever today. The actual initiation of the five-year program was "unquestionably the outstanding achievement" of the past year, said Dr. Allen. The success of the program was exemplified in the Minneapolis

workshop on the training of preceptors for administrative residents; the regional conference in Chicago for preceptor training; and the advanced institute at the University of Chicago, held for the first time this year in conjunction with the annual basic institute. Much of the education program is under the planning of Mrs. Mary Budde who was employed during the year as co-ordinator of graduate education. Also, Dr. Allen hailed the work of the committee on the administrator's relationship to the governing board as a major accomplishment. Guest speaker Haven Emerson, M.D., spoke very entertainingly on "Some Definitions by an Amateur" and touched upon many highlights from his hospital experience. Another interesting feature of the banquet was the presentation of the Past President's Badge. Miss Jessie Turnbull, former administrator of Elizabeth Stell Magee Hospital, Pittsburgh, was the recipient this year—although illness prevented her from receiving it in person.

At the General Educational Session held on Monday morning, William F. Russell, Ph.D., President of Teachers' College, Columbia University, gave a stimulating address on "Challenges of Liberty".



A. C. McGugan, M.D., Edmonton, advanced to Fellowship.

Inducted as president of the A.C.H.A. for the coming year, Frank J. Walter, administrator of Good Samaritan Hospital, Portland, Ore., succeeds Dr. Wilmar M. Allen. The president-elect is E. I. Erickson, administrator of Augustana Hospital, Chicago. The new first vice-president is Dorothy Pellenz, superintendent, Crouse-Irving Hospital, Syracuse, N.Y., and the second vice-president is a former Canadian, Dr. John C. MacKenzie, director of the Touro Infirmary, New Orleans.

Canadians Admitted or Advanced

The increased number of Canadians among the record number of those who were honoured by the College this year is indicative of the growing interest here in hospital administration as a profession. Those taking part are representatives of almost every province in Canada.

Advancement to Fellowship

A. C. McGugan, M.D., Superintendent, University of Alberta Hospital, Edmonton, Alberta.

Advancement to Membership

Sister M. Aloysius, Assistant Superintendent, Holy Family Hospital, Prince Albert, Sask.

Sister Anna Keohane, Superintendent, St. Therese Hospital, Tisdale, Sask.

Sister Annette Bujold, Superintendent, Hotel Dieu of St. Joseph, Campbellton, N.B.

H. E. Baird, M.D., Superintendent, Regina General, Regina, Sask.

Leonard O. Bradley, M.D., Executive Secretary, Canadian Hospital Council, Toronto, Ont.

Sister M. Camillus, Superintendent, Holy Family Hospital, Prince Albert, Sask.

Sister Calherine de Bologne, St. Paul's Hospital, Vancouver, B.C.

Sister Edith C. Harquail, Assistant Superintendent, Hotel Dieu, St. Joseph, Campbellton, N.B.

Sister M. Fabian, Superintendent, St. Joseph's Hospital, Chatham, Ont.

Ralph H. Gale, Superintendent, Saint John General Hospital, Saint John, N.B.

Sister Marie Alban, Superintendent, Ottawa General Hospital, Ottawa, Ont.

Sister Mary Farley, Superintendent, Regina Grey Nuns' Hospital, Regina, Sask.

Sister St. Flavie-Domitille, Superintendent, St. Joseph's Hospital, Sudbury, Ont.

Nominees

J. L. Murray Anderson, M.D., Medi-

Among the Canadians Honoured at A.C.H.A. Convocation



H. E. Baird, M.D.,
Regina.



L. O. Bradley, M.D.,
Toronto.



Sr. Annette Bujold,
Campbellton.



Sr. Flavie-Domitille,
Sudbury.



R. H. Gale,
Saint John.



Sr. Edith Harquail,
Campbellton.



Sr. Anna Keohane,
Tisdale.



J. L. M. Anderson,
M.D., Victoria.



Rahno M. Beamish,
Sarnia.



C. J. Kirk, M.D.,
London.



G. J. Bartel,
Montreal.



F. C. Kirby,
New Westminster.



Sr. Mary Ruth,
Vancouver.



C. U. Letourneau,
Montreal.



S. W. Martin,
Toronto.

eral Superintendent, Royal Jubilee Hospital, Victoria, B.C.

G. J. Bartel, Superintendent, St. Mary's Hospital, Montreal, Que.

Rahno M. Beamish, Superintendent, Sarnia General Hospital, Sarnia, Ont.

H. H. Browne, Superintendent, Herbert Reddy Memorial Hospital, Montreal, Que.

Mother Gertrude Donovan, Superintendent, Hotel Dieu Hospital, Kingston, Ont.

Sister Gertrude Jarbeau, St. Boniface Hospital, St. Boniface, Man.
Sister Jeanne-Mance, Superintendent,

ent, Hotel Dieu de Montreal, Montreal, Que.

F. C. Kirby, Superintendent, Royal Columbian Hospital, New Westminster, B.C.

Carman J. Kirk, M.D., Superintendent, Victoria Hospital, London.

J. Paul Laplante, M.D., Superintendent, Ste. Anne's Hospital, Ste. Anne de Bellevue, Que.

C. U. Letourneau, M.D., Superintendent, Queen Mary Veterans' Hospital, Montreal, Que.

Sister Louise Boulet, St. Paul's Hospital, Saskatoon, Sask.

Sister Marie de Loyola, Hôpital du Sacré-Coeur, Montreal, Que.

Sister Marie Joseph, Business Manager, Hotel Dieu St. Vallier, Chicoutimi, Que.

S. W. Martin, Assistant Superintendent, Toronto East General Hospital, Toronto, Ont.

Sister Mary Ruth, Superintendent, St. Vincent's Hospital, Vancouver.

Dora E. McMahon, Assistant Superintendent, Toronto Western Hospital, Toronto, Ont.

G. H. Stone, Assistant Superintendent, Vancouver General Hospital, Vancouver, B.C.

THE selection of medical personnel is of vital interest to the Hospital Board. It has been established both by law and precedent that the Board is responsible for the character and calibre of the medical work done in the hospital and, therefore, must be aware of the calibre of the men who are doing this work.

Closed Hospitals

In closed hospitals, in conjunction with universities, the medical staff usually have university appointments. The board, therefore, need have little worry as to the competence of the men doing the work. I cannot imagine a situation wherein a university would recommend an appointment without fully investigating the qualifications of the person involved and, therefore, I think it goes without saying that a hospital can accept on its staff anyone appointed by a university.

Open Hospitals

In open hospitals it is an entirely different matter. When a new doctor arrives in town, the first thing he wants to do is to get appointments in all the hospitals in that vicinity. The hospital board should take due care and allow a considerable waiting period before accepting any new doctor on its staff. In the first place, the board, through its superintendent, should investigate and see that the man is properly registered to practice in the province. In the second place, if he is an accredited member of the profession, he will belong to the local societies and the Academy of Medicine. It is impossible within a week or two to ascertain the degree of competence and ethical standards of any new applicant. Also, if a reasonable time is allowed to pass before the applicant is accepted, he will place greater importance on his appointment and will be much more liable to comply with hospital regulations and by-laws. Many hospitals have a credentials committee which reviews and is responsible for ascertaining the calibre of the applicant. In our hospital, applications are made directly to the superintendent and, after due investigation

An address presented at the A.C.S. sectional meeting held in Winnipeg, April, 1950.

Selection, Organization and Control of the MEDICAL STAFF

Donald R. Easton, M.D.,
Superintendent,
Royal Alexandra Hospital,
Edmonton, Alberta.

by him, are referred to the executive committee for approval. If members of the executive committee do not feel that they know the man well enough, or wish additional information, a sub-committee is appointed to investigate the situation and report on it. In fairness to the applicant, the matter should not be allowed to drag and, in order to avoid this, the man's name is placed on the agenda for consideration at each meeting until it is either accepted or rejected. In order to give the applicant an opportunity to perform work, pending the approval of his application, it is often advisable to extend to him the privileges of the house until the investigation is concluded. The superintendent can very quickly obtain from the provincial registrar the man's qualifications and registrar's opinion of him. In most instances this is sufficient evidence of his good standing to extend the privileges of the house to him on a temporary basis. By doing this, the different department heads can see the applicant in action and are in a much better position to advise the board through the superintendent as to whether or not they think he will be an asset to the hospital. I would strongly recommend that any doubtful appli-

cant be not accepted. The board has the right to refuse any applicant and should do so in the first instance when it is necessary. It is much better to defer an application for a short time than to appoint a man and then disbar him. Before any applicant is accepted, the regulations and by-laws of the hospital should be clearly outlined to him and he should be asked to sign them. Included in these regulations and by-laws should be a sworn statement to the effect that the applicant will refrain from fee-splitting.

With a first application for membership, a file should be opened. It should contain a report of all his past professional work, papers written, previous hospital and university appointments. In fact, it should be a complete running account of his medical status up to date. As far as the record of that doctor is concerned, this should be only the beginning. A complete record of his work at your hospital should be kept and this fact in itself is a strong factor in restraining him from any careless work or unethical practice.

I am sure that it is recognized by everyone that the medical staff as such has no power to appoint a new member. In our hospital, once a medical applicant has been favourably passed on by the executive committee, the matter is referred to the entire staff for their consideration at the next meeting. A two-thirds majority vote is required to pass the applicant but in actual practice once he has been passed by the executive committee, he is invariably accepted by the entire medical staff. Following a favourable vote by the entire staff, the applicant's name is referred to the hospital board who has the authority to appoint him.

Organization of the Medical Staff

The whole objective in organizing a medical staff is to see that patients in a hospital get the best possible medical and surgical treatment available. This is a matter that should be thoroughly impressed on members. Too often doctors consider that there are a lot of silly rules and regulations. They either give lip service to them or do not comply with them as they are formulated. I think that this is due

(Concluded on page 84)

Stephens Memorial Award

Announced by the

Canadian Hospital Council

DR. FRED W. ROUTLEY has been designated as the recipient of the George Findlay Stephens Memorial Award for 1950, by the Executive Committee of the Canadian Hospital Council.

The award is a memorial to the late Dr. George F. Stephens and it is bestowed only in recognition of noteworthy service in the hospital field in Canada.

Dr. Routley has served as the executive secretary-treasurer of the Ontario Hospital Association since its organization in 1924. His devotion in its service and his many abilities mark him as the man more responsible than any other for the O.H.A.'s development and progress. He has also served as director of its Blue Cross Plan for Hospital Care.

Although directly interested in its work and justly proud of the provincial organization, it stands to Dr. Routley's credit that he has never had an insular or purely provincial viewpoint. His interest and his work have been national and even international in their scope.

He ranked high among that group of far sighted men and women who organized the Canadian Hospital Council in 1931 and they chose him as the first president of the national organization, a position which he held until 1935.

For 27 years Dr. Routley was associated with the Canadian Red Cross Society, serving 16 years as Commissioner of the Ontario Division and 11 years as National Commissioner, a position he relinquished some two years ago to devote all of his time and energies to the hospital field.

With the Red Cross, Dr. Routley was an indefatigable worker, both in Canada and on the international scene, in peace and in war. His contribution to the development of

many Red Cross enterprises, his organizational ability and his contagious enthusiasm, brought him wide acclaim. He represented Canada at meetings and conferences in



Dr. Fred Routley.

Europe and conducted many relief and other agencies, including a period in Paris as medical director for the League of Red Cross Societies in 1926.

Not the least noteworthy of the Red Cross activities which benefited from his magic touch, was the program for the establishment of outpost hospitals in widely scattered frontier areas in Canada.

His jovial informality, friendly smile and cheerful mien have made "Dr. Fred" a host of friends in every walk of life.

Frederick William Routley was born in Victoria County, Ontario, and was educated in Lindsay and Toronto, graduating in medicine from the University of Toronto in 1907. He did post-graduate study in England and practised in Maple, Ontario, until 1921. He married

Gertrude Fry in 1908 and Dr. and Mrs. Routley still make their home at Maple, a short distance from Toronto.

In announcing the decision of the Executive Committee, Mr. R. Fraser Armstrong, President of the Canadian Hospital Council, stated that the George Findlay Stephens Memorial Award is the highest honour conferred by the Council. It is recognition of outstanding achievement on both the local and the national level. The award bears the name of one of Canada's greatest citizens and ablest administrators and it follows that those who receive it must, in large measure, possess his splendid qualities and be worthy of the respect and admiration in which George Stephens himself was held.

The award is in the form of a formal citation accompanied by a gift. The presentation of the award will be made on a suitable occasion in the near future.

* * * *

Story of the Award

Dr. George F. Stephens died in April, 1948. During his lifetime, he administered two of Canada's leading hospitals and he was regarded as one of the outstanding authorities on hospital administration on this Continent.

Among the honours accorded to him was the Award of Merit of the American Hospital Association. As president of that organization, as president of the Canadian Hospital Council, and in countless other offices of trust and responsibility, Dr. Stephens had a distinguished record. His personal integrity, energy, resourcefulness and kindness, earned for him the admiration, respect and affection of all who knew him. He was truly a great leader and a great Canadian.

No more fitting tribute to Dr. Stephens' memory could have been chosen, when establishing a Canadian meritorious award, than to name it the George Findlay Stephens Memorial Award. Each time this honour is bestowed upon a great Canadian in the field of hospital administration, the illustrious career

(Concluded on page 111)

Le Progrès de l'Organisation Hospitalière

Part II

ON bâtit des hôpitaux pour servir la population, et c'est le malade qui est la personne la plus importante dans un hôpital. C'est pour le bien des malades, quels que soient les détours que l'on prenne, que nous devons nous efforcer d'améliorer nos institutions. La tranquillité, le repos et la bonne nourriture feront beaucoup pour guérir les malades.

Nous avons fait du progrès en ce qui regarde les plans des chambres de malades. Nous n'aimons plus à nous voir en présence de grandes salles. On préfère des chambres d'au plus quatre lits, où les lits sont parallèles au mur extérieur et où il n'y a pas plus de deux lits éloignés de la fenêtre. Le malade jouit ainsi de plus d'intimité. C'est plus tranquille, et l'hôpital peut ainsi accommoder plus facilement les malades. L'unique argument en faveur des anciennes grandes salles, c'est le coût. Elles coûtent moins cher à construire et à munir de personnel.

Nous avons fait du progrès en ce qui regarde la disposition des cabinets réservés aux malades. Un grand nombre d'hôpitaux projettent, à l'heure actuelle, d'installer des cabinets juste à côté de chaque salle, ce qui mettra un terme au défilé des bassins de lit dans les corridors. C'est là un facteur important, puisqu'on fait lever vite les malades, mais il ne faut pas oublier que l'infirmière est souvent obligée d'aider les malades à se rendre aux cabinets. Par conséquent, il ne faut pas que cet espace soit trop étroit. Deuxième point: les cabinets modernes sont installés à 16 ou 18

Causerie prononcée à l'Assemblée de l'Association des hôpitaux catholiques, à Québec, le 27 juin, 1950.

H. G. Hughes,

A.R.I.B.S., M.R.A.I.C.,

Chef du Service des plans d'hôpitaux,
Ministère de la Santé nationale et
du Bien-être social, Ottawa.

pouces, au plus, du plancher, ce qui est trop bas pour ceux qui ont subi certaines opérations abdominales ou pour les gens qui sont très faibles. On pourrait facilement installer les cabinets sur une élévation de 2 ou 3 pouces en tuile ou en ciment. On pourrait aussi installer des barres d'appui de chaque côté des cabinets.

Service de Commissionnaire et système d'appel

On a fait beaucoup de progrès, au cours des dernières années, en ce qui regarde les systèmes d'appel des médecins et des infirmières. Deux principaux systèmes reposent sur la vue et sur le son. Il y a ensuite des systèmes qui combinent les deux. Beaucoup d'hôpitaux de cette province ont installé des systèmes de communication sonores entre malades et infirmières, et tous ceux qui les ont utilisés sont enchantés des résultats. "Hospitals", livraison de mai, contient un intéressant article sur l'installation d'un système sonore au St. Luke's Hospital, de Cleveland. Ce système permet à l'infirmière de replacer le haut-parleur à deux sens, sans se rendre au chevet du malade.

Le malade pèse sur le bouton d'appel; la veilleuse du lit, la lumière du corridor au-dessus de la porte et la lumière du signal au poste des infirmières s'allument en même temps. En apercevant la lumière du malade dans la boîte de contrôle, l'opératrice ferme le circuit et parle avec le malade afin de savoir ce qu'il veut et de dépêcher auprès de lui la personne qu'il faut.

Les malades aiment ce système parce que la promptitude avec

laquelle on leur répond apaise leur esprit, même s'il n'est pas possible de leur rendre immédiatement le service qu'ils demandent. L'hôpital est également satisfait parce qu'il y a moins de va-et-vient dans les corridors et, aussi, parce que la moitié des appels ont trait à des services qui peuvent être rendus par une autre personne qu'une infirmière diplômée et consiste en questions auxquelles la secrétaire de la salle peut répondre de vive voix.

L'ambiance de l'hôpital doit être aussi familiale et riante que les conditions le permettent. Par exemple, le Charlottetown Hospital, dans l'Ile du Prince-Edouard, qui a fait récemment d'importants agrandissements, a mis dans toutes les salles un papier-tecture spécial à dos de toile et à surface en plastique. Quand vous sortez de l'ascenseur, l'ambiance qui vous accueille est très agréable et comme familiale.

Isolement Acoustique

Aujourd'hui l'isolement acoustique est indispensable dans un hôpital bien conçu. Les corridors et tous les endroits d'où vient du bruit doivent être à l'épreuve du son. On ne voit pas pourquoi les salles d'opération et d'accouchement ne seraient pas isolées. De fait, beaucoup d'hôpitaux, aux Etats-Unis, ont isolé ces salles.

La seule précaution à prendre, c'est de poser les matériaux isolants, sur les plafonds de ces salles, avec des attaches et non pas seulement avec de la colle.

Plancher Conducteur

L'usage de plus en plus fréquent de gaz anesthésiques explosifs crée un risque d'explosion à l'endroit où on les utilise. Le danger le plus fréquent vient de l'électricité statique. On y remédie en égalisant le potentiel électrique de tout ce qu'il y a dans la salle, y compris les membres du personnel. C'est au moyen du plancher qu'on y arrive logiquement. Aussi s'est-on livré à beaucoup de recherches à l'aide de diverses substances, afin de satisfaire aux normes établies par la National Fire Protection Association.

Récemment, à la Upper Midwest Hospital Conference, un membre du comité nommé pour étudier le problème nous a dit que, jusqu'ici, les laboratoires des assureurs

(conclu à la page 88)

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ABSOLUTELY NEW! WEBRIL is the first and only true, non-woven, all-cotton felt! The result of years of research, released recently by Bauer & Black, WEBRIL Bandage has been thoroughly tested and approved in use by hundreds of doctors!

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RESEARCH TO IMPROVE TECHNIC...TO REDUCE COST



Food and Its Service

Sponsored by
the Canadian Dietetic
Association

THE advisability of having a separate diet kitchen within the dietary department of a small hospital is often questioned. Without a separate diet kitchen, it is argued, there is no overlapping of space, equipment, and staff; under the supervision of the dietitian, special food items for the various special diets are prepared by permanent members of the kitchen staff and the trays are simply checked by the dietitian. While this procedure is obviously the most economical in a small hospital, it does not afford sufficient opportunity for training in a hospital having a school for nurses. A student nurse is expected to take away with her a thorough knowledge of the procedures and theories involved in "special diets". Excessive duplication can be eliminated in the diet kitchen mainly by patterning the menu on the one being prepared in the main kitchen. This keeps down the number of food items to be ordered by the hospital; also some foods already prepared in the main kitchen can be used in the diet kitchen. In the Holy Family Hospital (160 beds) we are usually able to use soup from the main kitchen daily and sometimes the desserts are suitable for all patients on special diets. Vegetables are usually cooked in the diet kitchen because a good proportion of them have to be prepared without salt. However, if vegetables were steamed rather than boiled, it would be possible to use those prepared in the main kitchen. Meats are always cooked in the diet kitchen, mainly because it affords the student nurse an opportunity to learn the principles of meat cookery; besides, methods and recipes often have to be modified to give a product suitable for patients on special diets.

With regard to equipment, two household stoves, a steamer for serving trays, a refrigerator, and wagons for transporting trays of food, are sufficient. A section of the main kitchen's walk-in refrigerator is also

reserved for the diet kitchen. One section of this kitchen is used only for the preparation of baby formulas and, as no autoclave is available for our use, formula equipment is sterilized in a covered steam soup kettle. Whereas the dietitian's office would ideally be a glassed-in arrangement between both kitchens it is at present situated at one end of the diet kitchen. All dishes except those used

which she has actually worked with during her term there. Student nurses are encouraged to assume responsibility as quickly as possible and the response and results are most satisfactory. This sense of responsibility is developed in the student by the dietitian in order to allow her to devote time to the main kitchen, teaching, interviewing patients, purchasing, et cetera. The diet kitchen, however, is in a continual state of adjustment as the students come in relays every two to three weeks. This state cannot be avoided, whether there is a special diet section within the kitchen or not.

The Holy Family Hospital houses over 160 patients and those on special diets used to number up to over 40. This number for a staff of three nurses and one maid was out of proportion; neither was the equipment any longer suitable. To cut this group down, "light diets" were served from the main kitchen. The omission of certain foods from this light diet makes it possible for most gallbladder patients to be served from the main kitchen. These changes or substitutions are simply marked on the side of the menu sheet, and of course a patient count showing the number of "lights" is received from the floors daily. This change brought the special diet count to approximately 25. The diet kitchen also supplies the floors with custards, junkets, melba toast, protein milk drinks, egg nogs, and other beverages including baby formulas.

The duties of the diet kitchen nurses remain constant and are posted so that they may study them upon arrival in the department. Formulas, beverages, and desserts, are the main responsibility of the junior nurse. The intermediate nurse cares for vegetables and salads and is responsible for preparing correct amounts of food. The third or senior nurse is responsible for meats or the main course. She passes on to the others pointers she has picked up

(Concluded on page 110)

Advantages of a Special Diet Kitchen

Sister M. Camillus,
Administrator,
Holy Family Hospital,
Prince Albert, Saskatchewan

for cooking are washed with the balance of the hospital dishes in the dish-washing room. Trays are arranged on the various floors and brought back on the tray wagons.

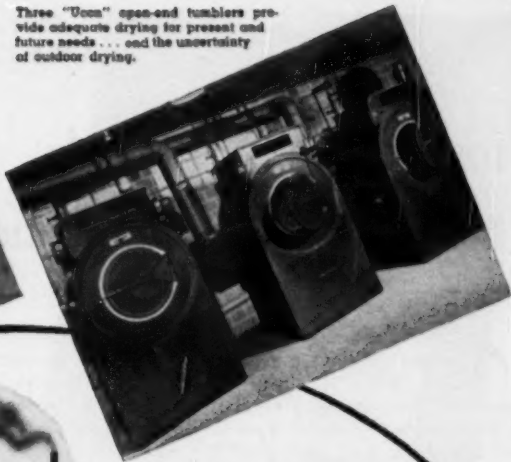
Training Student Nurses

The diet kitchen is regarded as a training unit and when the nurse has completed her six to eight weeks there she is equipped with a sound fundamental knowledge of food preparation and cookery. She has learned all she needs to know about diet in relation to disease, she will have been given the opportunity of explaining diets to patients who are being discharged, and by the time she leaves this department she usually is quite capable of taking full charge in the diet kitchen. With her she takes a special diet kit containing in mimeographed form copies of all diets used by the hospital and

"Silver Crest" Washers, in three sizes, replace old equipment, some of which dated back to 1918. Washroom is now adjacent to finishing area.



Three "Ucon" open-end tumblers provide adequate drying for present and future needs... and the uncertainty of outdoor drying.



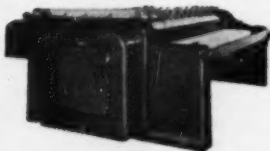
To speed the
WORK FLOW
To lighten the **LOAD**
and to provide for
FUTURE GROWTH



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Hosts of Hospital People Converge upon Atlantic City

ABOUT 8,000 enthusiastic delegates gathered in Atlantic City, N.J., to attend the mammoth 52nd annual convention of the American Hospital Association held from Sept. 18th to 21st. An excellent program offered a variety of stimulating addresses, discussions, forums, and sectional meetings, designed to appeal to the interest of every one.

Timely Theme

Most pertinent to the present-day situation was the theme featured at the convention this year—*Organizing the Hospital to Meet the Changing Scene*. It was gradually developed throughout three general sessions and was viewed from various aspects. Glancing into the future, speakers touched upon the nation's economy, medicine, and political implications. Financial matters were considered next with the overall problem being discussed as well as pre-payment plans, adequate reimbursement for the indigent, and voluntary plans for hospital integration. Professional practice rounded out the theme and was examined in the light of clinical advances in medicine, general practitioners and staff organization in small hospitals, multiple screening clinics, and community service for the hospital patient.

Finances

In the session dealing with finances, Hiram Sibley, Executive Director of the Connecticut Hospital Association, described the carefully thought out and organized program of his association to secure full payment for indigents from the state government. There was a very practical lesson in hospital financing here—one that could be considered seriously by all. During this session, it was repeated over and over that

standardized accounting and adequate cost accounting procedures were vital in presenting the hospital's case for adequate financing, to governments, Blue Cross, and other third party agencies, who pay the bill for the patient. The need for group action, state-wide, regional, and city, was emphasized by several speakers.

Small Hospitals Loom Large

Questions of interest to delegates from small hospitals were treated at a special forum. Topics, such as medical staff control, maintenance of nursing staff, and determining of rates were chosen by the audience and discussed by a panel of 25 hospital administrators. Although carefully planned, this forum was almost too popular. About 1,800 people were in attendance—which somewhat hindered the spontaneity and informality necessary for such a discussion.

Many sectional meetings took place throughout the convention

with interested groups meeting to discuss specific questions such as hospital design, problems in anaesthesia, financing, and purchasing. A section which met to study the future of nursing education had no ready solution to the problems involved. However, emphasis was given to the necessity of using several kinds of nursing personnel on the nursing team, as well as additional non-nursing assistants. Suggestions were made concerning shorter basic courses for training of the professional nurse, but it is evident that Canada is well in the lead in this respect.

Recommendations

The House of Delegates unanimously approved two major recommendations.

1. The establishment of an Association program of hospital standardization and approval.

2. An adjustment in the Association's dues structure, designed to increase revenue by about \$235,000 a year. About \$100,000 of this is to be used to finance the hospital approval program.

In other actions the House:

1. Asked that President Truman restore the Hill-Burton hospital construction funds that had been cut from the federal budget.

2. Reaffirmed the health care planning originally passed in 1944 and reaffirmed at other sessions.

3. Approved a joint resolution that asks that all who nurse for hire be licensed.

Final details of the standardization program have yet to be worked out but present plans call for the establishment of a 25-member Hospital Standardization Commission, including 13 hospital trustees, six administrators (including the chairman of the Council on Professional Practice), and six physicians.

In voting to increase dues, the Association was taking into consideration increased operation costs which were threatening to disrupt Association services, as well as the cost of the standardization program. In general, the new schedule will lower the dues of smaller hospitals and raise those of larger hospitals. The maximum increase will be 100 per cent and the average, 58 per cent. Personal memberships, in various classifications, will be up from

(Concluded on page 104)



Charles F. Wilinsky, M.D.,
elected A.H.A. President.

A method to help REDUCE your OXYGEN administration COSTS



Dominion Oxygen has available for hospitals an illustrated 16 page booklet which presents the facts concisely, shows you HOW and WHY your hospital can save time and money with a modern oxygen piping system. In ten minutes reading time, you can get the full story about:

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How did the Railway Strike Affect Hospitals Across Canada?

THE recent railway strike entailed grave economic losses to the nation, with even graver possibilities implicit in this breakdown of a vital service. For these reasons a survey has been made to ascertain to what, if any, extent the hospitals were affected. It was hoped, also, that information so obtained might be of assistance in the event of any similar emergency, either civil or military in origin. Out of 100 questionnaires sent to representative hospitals across Canada, large and small, urban and rural, an excellent sample was obtained in the 78 returns received.

The main impression received from these replies was that, in most hospitals, no significant deterioration in the quality of hospital service developed during the short strike period. This was largely due to the foresight of many administrators in ordering advance supplies, although it was emphasized by many of the hospitals that if the strike had lasted two or three weeks longer, the situation could easily have become very serious.

Most difficulties resulted from the lack of deliveries, lack of telegraph facilities, and disruption of staff travelling schedules. A few reported a slight effect on the daily census (3), on the length of stay (3), and on the number of admissions (5). In this last group there were 2 with a slight increase, 2 with a slight decrease, and one outpost hospital with the large increase for the month of August of 34 per cent! This latter figure may have been due to the fact that no transportation to larger centres was available, and also that some who were admitted would ordinarily have been outpatients.

Shortage of supplies was the big problem, with 29 hospitals reporting difficulties. Fourteen experienced shortages of medical and surgical supplies, ranging from surgical dressings and instruments to anaesthetics and alcohol; and peni-

cillin was seriously short in three hospitals. Where possible, substitutes were used and, in many cases, supplies had to be flown in by air or brought in by truck. One institution received supplies through private citizens travelling from a nearby city. Some borrowing between hospitals also helped. All but one were able to obtain dairy products locally, but 14 were unable to buy fresh foods, such as fruits, vegetables, and meats. Had it not been the harvest season, many others would not have been able to tap the local supplies, although as it was some had to pay retail prices. Seven hospitals had limited quantities of sugar, flour, and canned goods on hand. Two were short of fuel, and six had insufficient supplies for building and repairing. In the comments regarding the supply situation, it was noted that many communities were well served by truck and bus facilities, and in one city a "trucking committee" was formed to service the hospitals. In some cases, previously ordered freight supplies were at the local railway sheds, where some purchasers were allowed entrance immediately and others had to wait. Mail was limited in several instances. In Victoria, B.C., fish packers brought in deliveries stopped by the C.P.R. steamship walk-out. It is important to note the extra cost of obtaining supplies in an emergency, when it becomes necessary to buy locally, to buy retail, and to use the more expensive forms of transportation.

There was only one evidence of serious hardship to patients or staff during the strike, i.e., the hospital was unable to notify the relatives concerning the death of a patient, because of the lack of telegraph facilities. Delay in getting patients to needed hospital care occurred twice, again caused in one case by lack of telegraph facilities. Although a priority system was to have been established, several hospi-

tals were unable to send wires, perhaps due, it was suggested, to abuse of priority privileges by others. In any such emergency as this, hospitals should certainly have priority privileges for telegraph and mail facilities.

Many inconveniences were reported, of course, with staff members going on courses or holidays having to fly or take buses, and others being delayed in returning from holidays, with the accompanying difficulties in obtaining relief staff. Other inconveniences reported were: the delay experienced by delegates to the M.C.C.H.A. Convention at Charlottetown, P.E.I., in returning to the mainland; delay in calling for tenders for a new hospital; late shipments of drugs to western hospitals from the east; and several cases of inability to obtain written consent for operations.

Fortunately for many hospitals, good truck and bus connections were available, and the general consensus seemed to be that "the buses and trucks had done marvellous work". The time of year was a very important factor in making the situation easier, both because of passable roads and the harvest season. It was generally felt that "good roads had saved the day".

A large percentage had ordered extra supplies in advance which tided them over the critical period, although many were concerned over the situation which would have developed had the strike lasted much longer. Also, the confusion and apprehension which affected the hospital staffs placed additional strain on the administration. To sum up in the words of one administrator: "As in any emergency, it was found that confusion, if allowed, could have been the greatest immediate source of disturbance and disruption of service."

The True Meaning of Wealth

That country is the richest which nourishes the greatest number of noble and happy human beings; that man is richest who, having perfected the functions of his own life to the utmost, has also the widest helpful influence, both personal and by means of his possessions, over the lives of others.—John Ruskin.

For Rapid Disinfection of Instruments

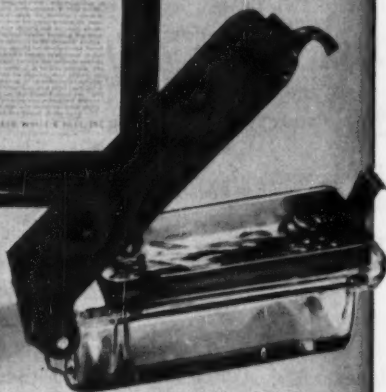
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PRICE
Per U.S. Gallon \$5.50
Per U.S. Quart \$1.85



B-P instrument container No. 300 is recommended as the ideal office container for use with the Solution.

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Check these additional features—

- Non-injurious to metallic instruments or keen surgical edges.
- Low volatility... will not irritate eyes, nose or throat.
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Compare the killing time of this superior bactericidal agent

Vegetative Bacteria	50% Dried Blood	Without Blood
Staph. aureus	15 min.	2 min.
E. coli	15 min.	3 min.
Strept. hemolyticus	15 min.	15 sec.

A BARD-PARKER PRODUCT



Pachysandra as a ground cover.

THE term "ground cover" means exactly what the word implies—viz., something with which to cover, or clothe, the ground. We dislike large expanses of bare earth and therefore set about to plant something in it which (we fondly hope) will grow into a soft green carpet. The type of carpet almost universally used in our part of the world is turf; and for a general covering, which must be reasonably comfortable to step on, it would be difficult to replace. It is not, however, the answer to all ground cover problems, regardless of circumstances, as we have come to consider it. Turf is composed of thousands of individual little grass plants grown in a solid mass and kept clipped to an even height; and there are few plants which have to take a more severe beating than they do. They are given many a job to do which they are ill-equipped to perform but for which they put forth a very staunch and brave effort nevertheless. The results may

Reprinted from the Journal of the Royal Architectural Institute of Canada, August, 1950.

Ground Covers and Their Uses

Helen M. Kippax,
Toronto, Ontario

be indifferent or extremely pathetic but we cling tenaciously to the practice. Where ground has to be walked on to a limited degree we are at present, at least, largely dependent on turf. However, if traffic is either unnecessary or undesirable much more satisfactory substitutes are available which, for the most part, will look after themselves when once established. These bid

fair to do the lawn mower out of a job.

What, then, are some of the most obvious circumstances where substitutes for grass would be suitable?

1. Areas in dense shade of low branched trees where grass is sparse and sickly at best.
2. Narrow strips between the house and service walk where a lawn mower is difficult to manipulate.
3. Out-of-the-way corners, often at the rear of the property, where it is not necessary to walk very often.
4. Steep slopes where mowing is almost impossible and where grass soon becomes brown and dry.
5. Areas where the traffic is too heavy or concentrated to allow grass plants to survive, as under a gate, or on a terrace equipped with chairs and tables for outdoor living. The appropriate *ground cover* here is not found in the plant world but in some form of attractive paving which can take the wear-and-tear.

These are only a few of the most difficult conditions for lawn maintenance but if even these were eliminated, no little amount of



SURFACE-CHROMICIZING*

When gut is chromicized after strands are spun and dried, chrome concentration is very high in surface layers and relatively low in the core. Inner core is digested rapidly—the highly chromicized periphery survives for prolonged periods.



ETHICON TRU-CHROMICIZING

Individual ribbons of gut are soaked in chrome bath before they are spun into strand, permitting uniform deposition of chrome. The strand thus has the same chrome content from periphery to center.

Why Ethicon's Tru-Chromicizing Process MEANS BETTER SUTURES

The fate of the absorbable suture after implantation and wound closure, and its reactions in the host, are the ultimate test of the suture's quality and dependability.

Today chromicized gut is widely used because of its resistance to digestion until healing is accomplished. In this aspect, the chromic suture must possess these attributes:

1. Sufficient chrome content to withstand premature digestion.
2. Chrome concentration must not be so excessive that fragments of the suture resist digestion and persist in tissue. This condition frequently leads to knot extrusion.

In order to obtain a product having the highest possible degree of uniformity, Ethicon chromicizes raw gut strands in the ribbon stage. This more meticulous process was named Tru-chromicizing. The alternative method, used by others, called

surface-chromicizing, involves the dipping of the finished, spun and dried suture strand in a chrome bath. These are the results of the two methods:

Surface-Chromicizing

In enzyme solution, the core of most surface-chromicized gut digests readily, leaving a hollow cylinder which separates into ribbons. This cylinder may be excessively resistant to enzyme action and remain as an undigested foreign body indefinitely.

Tru-Chromicizing

Ethicon Tru-chromicized gut exhibits uniform enzyme resistance throughout digestion. It digests from the surface inward, and retains its integrity as a unified suture until dissolution approaches completion.

Total digestion eliminates the danger of knot extrusions and sterile stitch abscesses.

What Tru-Chromicizing Means

1. Less interference with healing through minimized foreign body reaction.
2. High tensile strength of suture retained for the healing period, followed by complete absorption.
3. Uniformity in those physical and physiologic characteristics essential to accurate surgical technic.

*To illustrate this comparison, small laboratory trays are used. In commercial production, surface-chromicizing is done under tension. Both processes are performed in large vats.



Dr. Malcolm T. MacEachern Is Honoured by McGill University

AS a well-deserved tribute to a man who has done, and is doing, so much for the hospital field, an honorary L.D. degree was bestowed upon Malcolm T. MacEachern, M.D., C.M., D.Sc., F.A.C.P., F.A.C.H.A., by McGill University on October 6th of this year.

Because of his Canadian background as well as his long and active association with the American College of Surgeons, Dr. MacEachern is a familiar and revered figure wherever hospital people gather. Born in Lindsay, Ontario, he obtained his teacher's diploma there, then graduated from McGill University Medical School in 1910. His career began as Medical Superintendent of Montreal Maternity Hospital, followed by nine years as administrator of the Vancouver General Hospital. In 1923 he went to Chicago to become Associate Director of the A.C.S. Almost synony-



Malcolm T. MacEachern, M.D.

mous with his name is the successful program of hospital standardization which was developed under his sponsorship by the A.C.S.

At present he is Director Emeritus and Director of Hospital Activities, American College of Surgeons. He also holds the position of Professor of Hospital Administration and Director of that program at Northwestern University, Chicago.

Real evidence of Dr. MacEachern's influence is the respect shown for his brilliant writings. Who has not consulted his *Hospital Organization and Management* (familiarily known as the "hospital bible")? A Spanish edition of this comprehensive reference book is now in preparation. His other work, *Medical Records in the Hospital*, has further spread his name and fame across America. Also, his by-line has appeared in numerous journals.

Many are the honours and citations which have been heaped upon Dr. MacEachern, from the A.H.A. Award of Merit to the City of Winnipeg Crest, and he holds memberships, both honorary and active, in innumerable organizations. Now he has received his Doctor of Laws degree from his Alma Mater, a fitting locale for this further demonstration of the high esteem in which Dr. MacEachern is held from coast to coast. ●



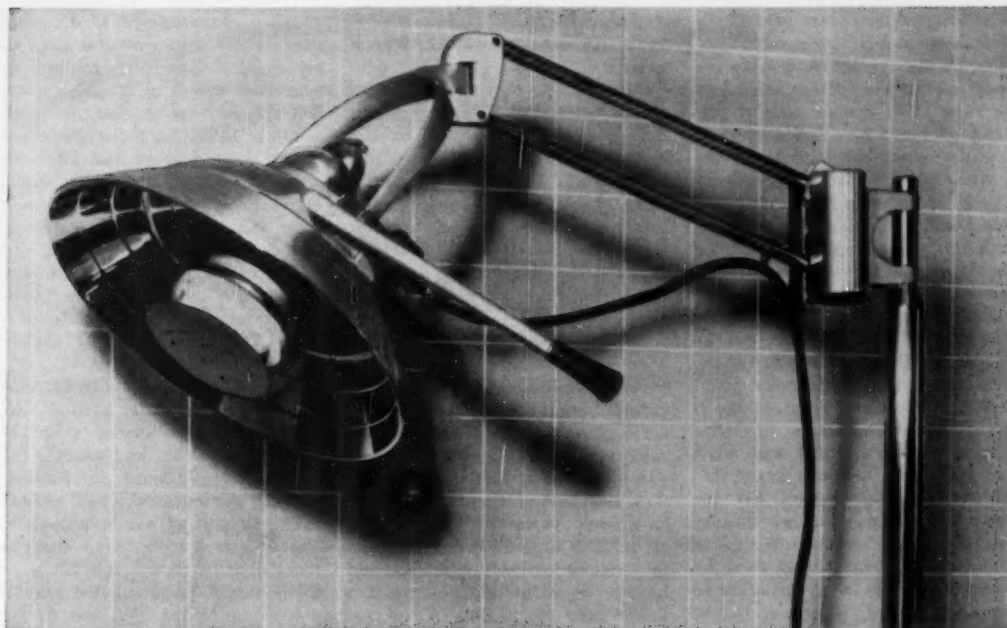
labour-saving could be instituted. At the same time, we would create an improvement in appearance, for unhealthy growth is always a disturbing element. True, in many cases, with constant care and attention, a measure of success can be achieved. In the days of head gardeners with several assistants, this was not difficult to provide. Those days are past and gone, however, and the present-day garden is frequently looked after entirely by the owner or, at best, by the man who comes once a week to cut the grass. This fact brings emphasis upon one of the most important requisites of this modern garden we now talk so much about, i.e., *ease of maintenance*. The coddling of difficult and delicate subjects is consequently inconsistent and must go by the board. No more effective point could be found to start this discarding of the weak and concentrating on the fittest than in our lawns. Considering the many weary

hours spent in their mowing, watering, fertilizing, rolling, et cetera, it is obvious that wherever we can cut down on our lawn areas, especially the difficult ones, the more time can be salvaged for other activities.

Under Shade Trees

Referring back to example No. 1, *Areas in shade of trees*, it should be borne in mind that the poor growth of grass here was not entirely due to lack of sun, but also to the presence of the feeding roots of the trees which extend roughly as far out from the trunk as the "drip" of the branches. These, in their zeal for the welfare of the tree they support, steal all the moisture and nourishment from the upper layer of the soil where they work, so that the grass has nothing upon which to feed. In substituting ground covers for grass, under these circumstances, it would only be reasonable to give the new plants a good start toward combatting this

strong competition by the incorporation in the soil of both fertilizer and a moisture-holding medium such as manure, leaf mold, or peat moss (the latter being most easily procured as it is available in large or small bales from most seed houses). Given a good start, a healthy growth is possible of such good ground cover plants as *periwinkle*, *pachysandra*, *euonymus coloratus*, *ajuga*, *English ivy*, *sedum ternatum*, *violets*, *moneywort*, besides a great variety of native plants. Indeed nature gives some of the best examples of the appropriate use of ground covers and we could do no better than turn to her for a lesson! Is not one of the charms of the open woods (i.e., those not choked up with underbrush) the existence of a luscious green carpet spread in great masses over the ground under the trees? Nature has no lawn mower and requires no outside plans. She also has a marvellous appreciation of the system



Castle No. 52 Explosion-Proof Safelight

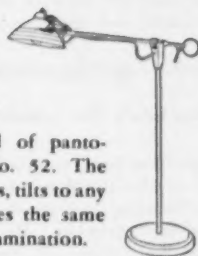
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of utilizing a temporary crop if the permanent one is late coming into being in the spring. A well known woods which is carpeted throughout the summer by a solid mass of tiny maple seedlings was visited recently in early spring when, much to the surprise of the visitor, who knew it only in summer, the woods-floor was found to be completely clothed with the grey-green foliage of the little dicentra known as "Dutchman's Breeches", intermixed with yellow Adder's Tongue, giving a completely different aspect to the hillside. Not a sign was there of the baby maples so prominent last year! A visit two weeks later, however, found the Dutchman's Breeches getting noticeably limp and weak and the maple seedlings firmly taking over for the summer. For low green carpets we find her making good use of such things as *violets*, *foam flower*, *bunchberry*, *creeping snowberry*, *bearberry*, *partridge berry*, et cetera, according to the soil conditions present in each spot under her control; and for taller ones she has the numerous *ferns*, *Solomon's seal*, *false Solomon's seal*, *trilliums*, *Jack-in-the-pulpits*, *may-apples*, *bracken*, and others too numerous to mention. She uses them only if they are quite happy in the area concerned, refusing to waste her time on subjects of indifferent health, and she uses them

in sufficiently generous quantities to do the job well—a point worth emulating.

Many of the above native plants are, of course, not adaptable to our city conditions and should be left in their natural habitat, but *violets*, *foam flower*, *St. John's wort*, and *ferns*, seem quite adaptable. *St. John's wort* likes a certain amount of sun but the others seem able to establish themselves quite contentedly in shady corners of our city gardens.

Use of Weeds

To ardent gardeners who have wrestled for hours against the ubiquitous weeds which plague our lawns, it will undoubtedly seem like rank heresy to suggest that even they might have their uses. In fact they may hold excellent possibilities as ground covers in difficult places provided they are used only when they can be kept within bounds and have no opportunity to escape into flower beds and lawns. There are many spots where their use may be well worth looking into. Some of them, indeed, are quite attractive little plants if it were not for the bitter prejudice we have against them when they force themselves upon us where they are not wanted. Is not one of the main requisites of a ground cover that it shall be able to spread quickly and cover the ground? That surely is an out-

standing characteristic of our common weeds! Two examples come to my mind — one, the ground ivy (variously known as creeping Charlie, gill-over-the-ground, creeping Jennie). It has an attractive round leaf of a good green and, when allowed to go its own way in a shady, rather damp spot, will make a rich green mat hard to beat. Naturally it must not be used where it can make its way into surrounding lawns or it will step in and completely take over in double-quick time. The same applies to moneywort and sedums.

The use of some of our familiar weeds would well bear looking into, for example, for narrow strips of ground bordered by concrete or stone (as mentioned in example No. 2); for out-of-the-way corners where no attempt has been made to keep a mowed lawn (as in example No. 3); or as in example No. 4—a shady ravine lot where the natural ground cover has been lost during building operations and all kinds of rank untidy growth are taking over. If these odd corners and narrow strips are near the residence, a more refined type of covering is appropriate and can be extremely decorative—much more so than grass. If these spots are provided with fertilizer and a good moisture-holding material, one can anticipate a healthy growth of such plants as *periwinkle*, *pachysandra*, *ajuga*, *violets*, *sedum ternatum*, for shady areas; for sun, other sedums can be used, and such flowering plants as *thyme*, *phlox subulata* and the attractive little *veronica rupestris*, with its lovely blue flowers.

Steep Slopes

As for the long steep slopes, the absolutely ideal solution does not yet seem to be forthcoming. There are a number of shrubs which will give a good performance if provided with the proper attention in the way of pruning to keep them close to the ground so that they will spread instead of ascend. However, on hillsides of considerable extent this is no small task and, if once allowed to get out of bounds, it is very much of an undertaking to control them. For large hillside areas some of the plants usually employed are *forsythia suspensa*, *Regel's privet*, *kerria*, *Japanese barberry*, *Hall's honey-*

(Continued on page 100)

New Controller Appointed at Hospital for Sick Children

Mr. C. A. Sage has been appointed Controller of the Hospital for Sick Children, Toronto, and commenced his duties in September. He succeeds the late Harry R. Smyth. Born at Alton, Ontario, Mr. Sage has had wide experience in banking and financial institutions. He is a certified public accountant, a certified general accountant, and a charter member of the Canadian Credit Institute. In 1941 he became associated with the Ontario Blue Cross Plan when it was first launched. As assistant director and comptroller of the Plan he has seen it grow to an enrolment of over 1,400,000 persons. Mr. Sage has been highly praised for his contribution to the administrative efficiency of the plan during its phenomenal development.



C. A. Sage.

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50-1



Notes on Federal Grants

Construction

A new 187-bed hospital being built for the Sisters of Charity in North Sydney, N.S., has been awarded a grant of \$188,300, and the Blanchard Fraser Memorial Hospital, Kentville, will receive \$21,000 towards the cost of converting that part of the hospital formerly used for nurses' accommodation to provide space for 21 additional patients.

A payment of \$6,878 has been made to help offset the cost of an addition to the Tuberculosis Control Centre in Saint John, N.B., which will provide space for admission, consulting, and examining rooms, as well as administration offices.

Quebec health services will be benefited by a grant of \$67,600 to help finance the building of the new 63-bed Barrie Memorial Hospital in Ormatown, and \$181,500 towards the cost of building the new 120-bed Julius Richardson Convalescent Hospital at Chateauguay Basin. This hospital is for children recovering from all types of illness.

Hospitals in Hamilton, Gravenhurst, and Rainy River, all in Ontario, have been awarded more than \$217,000 for construction. St. Joseph's Hospital, Hamilton, received \$149,000 for its five-storey extension which is to provide space for a 102-bassinets nursery and 115 beds for maternity and surgical cases. In Rainy River, a new Red Cross Hospital being built will have 14 beds and a 5-bassinets nursery. The enlarging of the Muskoka Hospital for treatment of tuberculosis at Gravenhurst, to accommodate 42 more beds, will be assisted by a contribution of \$52,500.

In Manitoba, the St. Boniface Hospital is planning an extension which will give space for 435 more beds, 36 bassinets, and enlarged facilities for surgery, obstetrics, paediatrics, and general medical work, thereby improving teaching and research facilities for the University of Manitoba's medical school. When this construction, for which a grant of \$447,000 has been allotted, is finished

the 73-year-old 140-bed north wing will be torn down. A grant of \$19,000 will be given to Beausejour General Hospital, which will have space for 16 beds and nine bassinets.

With the completion of a new nurses' residence at the municipal hospital in Taber, Alberta, space for 12 beds and an 8-bed nursery is being made available in the basement of the existing hospital. These alterations will be partially financed by a grant of \$12,600. A new 20-bed hospital, being built at Magrath, Alta., to replace an obsolete one, will be assisted by a grant of \$22,600.

In New Westminster, B.C., another addition to the provincial mental hospital which will house 96 more beds is to be the beneficiary of a \$90,000 grant from the federal government, and the King's Daughters' Hospital in Duncan, on Vancouver Island, will receive for alterations, made to provide space for six additional cots in the children's ward, a grant to meet one-third of the cost.

Mental Health

New Brunswick's first mental health clinic, now in operation in the Saint John General Hospital, Saint John, will be aided with a grant from the national health funds. The establishment of the Saint John Clinic is in keeping with the mental health program that is being inaugurated by the province. The psychiatric staff is being provided by the Provincial Mental Hospital at nearby Fairville, N.B., and money will also be granted to pay the salaries of four medical interns to assist the regular medical staff during the summer months. Federal grants will also cover the cost of supplies for the clinic and salaries for nursing and stenographic staff. Bursaries have been provided for three students for study in psychiatric social work; two will enrol at the Maritime School of Social Work, Halifax, and the other at the University of Toronto. The costs for the mental health program are estimated at about \$9,300.

Personnel Training

Bursaries have been awarded to 17 persons from British Columbia for advanced training in special branches of public health. Eleven nurses will take a year's course in public health nursing at the University of British Columbia. Two other nurses have been awarded bursaries to study at Columbia University, New York. One will spend a year studying administration of public health nursing services while the other will take a year's course in the teaching and supervision of public health nursing. Two doctors will take a year's post-graduate work, one in medical care and industrial health at the University of Michigan and the other in public health at the University of Toronto. A dentist will receive a year's course in public health dentistry at the University of Michigan. A senior technician from the Vancouver General Hospital will take a course in histopathology at the medical school of the University of California, San Francisco. The total cost of the bursaries will be more than \$22,300.

An estimated \$10,000 will be spent in bursaries for fourteen persons from Newfoundland and Nova Scotia to study in various public health fields. Three nurses from Newfoundland will study public health nursing at the University of Toronto, while a fourth nurse will take a year's training as a clinical supervisor in medical nursing, also at the University of Toronto. Five health inspectors have received bursaries which will enable them to take a course in sanitary inspection given by the Canadian Public Health Association; and funds have been set aside to enable two officers from the provincial health department to attend a special course given by the American Psychiatric Association in St. Louis, Mo. In Nova Scotia two sisters have been awarded bursaries to take courses in psychiatric nursing at the Catholic University of America, Washington, D.C. A doctor from the Point Edward Sanatorium will receive funds to take a course in bronchoscopy at the Chevalier Jackson Clinic, Philadelphia.

Eight nurses, a laboratory technician and a doctor, all from the prairie provinces, have been awarded bursaries for special training in var-

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(area 162 square inches)



Fig. 1



Fig. 2



Fig. 3

A treatment using Jelonet pressure dressings and plaster fixation

CASE-HISTORY—The patient, a young man, was admitted to hospital, having been burnt by an electric blanket. The raw area measured 162 square inches. Excision of the burnt area was performed on the same day. Jelonet was applied. Fixation by Gypsona plaster of Paris bandages applied over the whole area, abdomen and thigh. The patient was given a blood transfusion.

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The patient was discharged to duty 7 weeks later.

The details and illustrations above are of an actual case. T. J. Smith & Nephew Ltd., Hull, England, manufacturers of "Gypsona" and "Jelonet", are privileged to publish this instance, typical of many, in which their products have been used with success in the belief that such authentic records will be of general interest.



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ious phases of public health work. At an estimated cost of \$7,600, eight Manitoba nurses will study public health nursing at the University of Manitoba, and a technician from the provincial laboratory in Winnipeg will take a course in medical parasitology at the Laboratory of Hygiene, Ottawa. Also, the superintendent of the Saskatchewan Hospital, North Battleford, will take a month's training in Toronto in the reading and interpretation of electroencephalograph recordings.

Seven residents of Alberta will receive bursaries. A laboratory technician from the University of Alberta's dental clinic will take a course in the techniques of controlling dental caries at the University of Toronto. Another bursary for a two-year course in dental hygiene at Northwestern University, Chicago, has been awarded to a Calgary resident. Two technicians from Edmonton, will receive bursaries for a year's study at the Northwest Institute of Medical Technology, Minneapolis, Minn. Three nurses have been awarded courses: one will take a four-month course in operating room techniques at St. Michael's Hospital, Toronto; another an advanced course in obstetrics at the University of Alberta; and the third a six-month course in paediatric nursing at the Children's Memorial Hospital, Montreal.

A grant of \$1,500 will also assist in meeting the costs of training personnel in a hospital administration course which is offered by the extension department of the University of Alberta. With the need for assistance in hospitals throughout the province, grants will also help in a program of training nurses' aides. The cost of the training program is estimated at \$25,000.

A grant has been authorized to pay the salary of an assistant instructor of nurses at the St. John's General Hospital, St. John's, Nfld., as a further move to improve the quality of nursing education in that hospital.

Public Health

An estimated \$28,000 from Ontario's share in the national health grant will be used for further development of county health units in various parts of the province. The money will provide 10 units with increased staffs. Veterinarians will

be added to the health units of six counties to supervise and inspect food supplies. They will also aid in an educational program for food handlers and do special studies in animal diseases which might relate to humans. Sanitary inspectors will be added to the staff in two counties. One unit will have funds set aside to pay the salaries of a school medical officer and an additional public health nurse. Another county will have an additional nurse so that public health work may be expanded in the schools and a more adequate service given for prenatal cases.

Federal funds have been allotted to Saskatchewan for the employment of 12 additional public health specialists. The Saskatchewan Hospital at Weyburn has added a psychiatrist and a psychologist to their staff. Both of these will assist with training courses, in their respective fields, for ward personnel. Also the Saskatchewan Hospital at North Battleford will add two more psychiatrists to its staff.

The Regina General Hospital will require the addition of two psychiatrists and a psychiatric nurse now that the Munro wing of the hospital has opened. The present staff serves not only this hospital but also several nearby towns. The Yorkton and Prince Albert regions will have the help of two more teacher-psychologists in developing a program to prevent mental illness. Both appointees received a year's special training in this type of work at the University of Toronto. Grants also allow for the employment of a nutrition consultant to study the problem of proper food standards for child welfare. A medical student will be hired to assist the medical health officer in the Weyburn region and grants will further allow for the full-time employment of a sanitarian to supervise the 30 sanitary officers stationed in various districts throughout the province.

The revision of courses at the University of Saskatchewan's school of nursing and the addition of an assistant professor of public health nursing, made possible through federal grants, will enable nurses from Saskatchewan to obtain specialized training in public health without leaving their own province. Federal aid will also be given for a course

to train more hospital laboratory technicians at Regina College. The former 18-month course has been lengthened to two and a half years to provide a better practical training and increase the number of persons in this specialty. Grants will cover the costs of additional laboratory equipment needed to get the course under way. Both of these projects are estimated to cost \$13,000 during the current fiscal year.

The federal government has agreed to meet most of the costs of operating the recently-organized health unit for the county and city of Sherbrooke, Que. More than \$60,700 have been set aside from the grants to finance a preventive medical service for the almost 60,000 people in the area. The grant will meet the cost of serums and vaccines and also salaries for the staff. The unit will consist of a medical director, an assistant director, a specialist in tuberculosis, a technician for tuberculosis control work, a sanitary engineer, 14 public health nurses, two sanitary inspectors, two veterinarians, clerical staff, and a dentist working part time.

Canada's second glaucoma clinic will be established in the St. Sacrement Hospital, Quebec. The new clinic will be a treatment and research centre. A professor of ophthalmology at Laval University will direct the clinic, and other staff members will include an assistant to the director, a nurse, and a social worker. The \$14,500 grant for this project will cover the costs of staff salaries and special technical equipment for the clinic.

Tuberculosis

Prior to the opening of the new sanatorium at Corner Brook, Nfld., an x-ray survey will be carried out in the west coast area, federal grants covering part of the cost. The survey will be of value not only in discovering cases requiring immediate treatment but also will be a guide to the clinical services needed in connection with the new sanatorium. Federal funds will be made available for the director of the Institute of Microbiology of the University of Montreal to visit Newfoundland in order to confer with provincial health officials on the possible development of a B.C.G. immunization program there.

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C.I.P.S. Sets New Date for Appointment of Interns

THE Canadian Intern Placement Service is an important activity of the Canadian Association of Medical Students and Interns. Through C.I.P.S., final year students are afforded the opportunity of selecting the best internship available and Canadian hospitals are provided with a clearing house to ensure that they receive a high proportion of their preferred applicants.

The Canadian Medical Association, which maintains a list of Canadian hospitals approved for internship, assists the operation of C.I.P.S. in a consultative and secretarial capacity because it considers the service to be advantageous to both students and hospitals.*

The medical schools of Canada may be divided into two classes on the basis of the time of the award of a degree in medicine. At McGill, Queen's, Toronto, Western Ontario, and Alberta, the degree is awarded at the end of the fourth medical year and the graduates of these schools are free to seek internship wherever they desire. At Dalhousie, Laval, Montreal, Ottawa, and Manitoba, a fifth undergraduate year is spent in an internship which is arranged by the University concerned.

Three years ago, in 1947, the Association of American Medical Colleges announced a co-operative plan for the appointment of interns. The essential feature of this plan was the adoption of the date November 15th, of the year preceding the assumption of duties, as the time when all appointments would be announced. At that time (1947) the opinion of hospital administrators and deans of Canadian medical schools was canvassed by the Canadian Medical Association and an overwhelming majority indicated that the adoption of a uniform date

was desirable. Accordingly, C.I.P.S. has operated in conformity with that plan.

At the last annual meeting of the Association of American Medical Colleges, it was decided that the date of announcement of appointment to internships in the United States would be postponed from November 15th to the third Tuesday in February. The essential reason for this change is to permit a better evaluation of the student on the basis of part of his final year's work and, consequently, a more accurate report from his dean to the hospital at which he is an applicant.

A uniform date for the announcement of appointment to internships in the United States and Canada appears to be still desirable. Canadian students seeking appointments in American hospitals, American students applying to Canadian hospitals, and American students graduating from Canadian schools, will all benefit. Canadian hospital administrators will receive more informative reports on applicants in view of the later date; and all Canadian medical schools where graduates are free to choose their internships will co-operate with C.I.P.S. on this basis.

For these reasons, it has been decided to amend the regulations of the Canadian Intern Placement Service to conform with the dates selected in the United States. A full outline of the amended procedure is appended (see below).

Survey

While the above decision was pending, the Canadian Hospital Council made a survey of the hospitals approved or commended for internship by the C.M.A. in order to obtain opinions concerning the proposed change in the date for intern appointments. On the basis of replies received, it would appear that the majority of hospital authorities approve the reasons for the change

and are agreeable to making appointments at the later date.

Appendix

Amended C.I.P.S. Procedure for Appointment of Interns

The Canadian Intern Placement Service (C.I.P.S.) is an activity sponsored by the Canadian Association of Medical Students and Interns (C.A.M.S.I.) with a view to providing Canadian students with the widest possible choice of internships; and approved and commended Canadian hospitals with the widest possible choice of interns. C.I.P.S. does not guarantee to any hospital that interns will be supplied, nor to any student that an internship will be available at any specific hospital.

The function of C.I.P.S. is confined to final year students at participating Canadian medical schools who are seeking their first rotating internship in approved and commended Canadian hospitals. Physicians who are already graduated at the time of application, or who are seeking training in special fields, are unsuitable for processing by C.I.P.S. and should not be included in lists submitted by hospitals.

1. Each final year medical student will apply for internship to the Administrator or the Intern Committee of each of the hospitals in which he desires to intern. These applications must be in the hands of the hospitals before (October 15th) January 15, 1951.

2. The medical student will enter on a Student Form (supplied by the Canadian Intern Placement Service) the names of the hospitals to which he has applied for an internship, in the order of his preference, and send the form to the C.I.P.S. before (October 15th) January 15, 1951. Each student form must be accompanied by the required fee of \$1.00. (Cheques should be made payable to "Secretary-Treasurer, Canadian Intern Placement Service".) It is recommended that students make application to a sufficient number of hospitals to ensure assignment to one of them.

3. The hospital administrator or Intern Committee will rank the applicants in the following two groups, from an investigation of the applications, personal interviews, hospital examinations, letters of recommen-

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1950 Convention of the C.S.R.T.

THE eighth annual convention of the Canadian Society of Radiological Technicians opened on Thursday, September 7th, in Vancouver. Mayor Thompson welcomed the delegates and visitors on behalf of the city. Dr. W. L. Sloan spoke on behalf of the radiologists of British Columbia and expressed the hope that the convention would be a successful one. Percy Ward extended a welcome on behalf of the B.C. Hospital Commission. He was followed by S. M. Smith, President of the B.C. Division of the C.S.R.T., who thanked the three speakers for their good wishes and then turned the meeting over to H. M. Welch, President of the C.S.R.T.

Business was carried out briskly and the reports of various officers and committees were read and adopted.

The most important item of progress which was discussed at the meeting was the proposed Teachers' Training Syllabus which was drawn up by a committee of radiologists under the Canadian Association of Radiologists in conjunction with officers of the Canadian Society of Radiological Technicians. This stupendous work has been under consideration for several years and the brief was immediately passed and adopted by the C.S.R.T. and will be the standard curriculum for all training centres in Canada. After a few minor changes the syllabus will be printed and distributed. All members of the C.S.R.T. expressed their gratitude to Dr. G. Gill of Montreal, who presented the brief, and asked him to take back to the Canadian Association of Radiolo-

gists grateful thanks for the splendid work they had done and the advice and assistance they had given to the C.S.R.T.

Many splendid events for the entertainment of guests were held and the annual dinner and dance was attended by over two hundred. Dr. Wallace A. Wilson, a former president of the Canadian Medical Association, gave a very witty and entertaining address, after the dinner, which was enthusiastically received by all.

The final event of the convention was a four hour cruise up Howe Sound on a beautiful private yacht which was lent by Harold Jones, Commodore of the Royal Vancouver Yacht Club. This proved to be one of the most enjoyable events of the four day period and was thoroughly enjoyed by about sixty members and visitors. The convention closed officially after this event and the whole affair was announced an outstanding success and a credit not only to the B.C. Division, but to the society as a whole.

Officers Elected

Honorary President: Dr. Norman H. Gosse, President C.M.A., Halifax, N.S.

President: Mr. William Doern, R.T., Winnipeg, Man.

Vice-President: Mr. Albert Perry, R.T., Bridgewater, N.S.

Secretary-Treasurer: Mr. W. Q. Stirling, R.T., Vancouver, B.C., re-appointed for a third term.

Representatives to the Board of Directors: Dr. E. A. Petrie, Saint John, N.B., (appointed by the C.M.A.); Dr. G. Gill, Montreal, Que., (appointed by the C.A.R.).

—W. Q. Stirling, R.T. ●

←
ditions, or any other data that may be available:

Form A—Those whom the hospital definitely desires as interns.

Form B—Those whom the hospital will appoint should any applicants on Form A be eliminated, i.e., alternates or second choices, listed in order of preference.

The hospital will enter the names of the applicants in these two groups

on Forms A and B respectively (to be supplied by the C.I.P.S.) and send forms to the Canadian Intern Placement Service on or before (November 5th) February 10, 1951. It is strongly recommended that hospitals indicate their order of preference for all applications received.

4. The C.I.P.S. will assemble the student forms and the hospital forms A and B and, by a process of dovetailing, will assign to each hospital

the students appearing on Form A. In cases where a student's name appears on more than one Hospital Form A, he will be assigned to the hospital appearing highest on his preference list (Student Form.) His name will then be deleted from all other Hospital Forms A on which it appears, thus creating vacancies for alternates in these hospitals. The C.I.P.S. will then fill these vacancies from Form B, submitted by the hospitals using the same method as followed above. By this means, the hospitals will control the filling of gaps on their Forms A. The C.I.P.S. will continue this process of dovetailing hospital and student forms until the lists of choice have been exhausted.

5. The C.I.P.S. will serve only those students desiring to intern in Canadian Approved or Commended Hospitals. Students desiring to intern in hospitals other than those on the Canadian Medical Association's Approved or Commended List will be required to make their own arrangements for such internships. If a student desires to apply to both Canadian and American hospitals, C.I.P.S. will handle his application only if the Canadian hospitals stand higher on his preference list (i.e. Student Form) than the American ones.

6. The C.I.P.S. will send to each hospital, by telegram, a list of all the medical students assigned to it by the above procedure on (November 15th) February 20, 1951, and on the same date, will advise each medical school of the assignment of its students. Hospitals should immediately notify the students assigned, that they in fact are offered an appointment. This notification should be carried out by wire, in the case of students residing at a distance, and it should be dispatched on the date of (November 15th) February 20, 1951.

In turn, students so assigned and accepting the appointment should reply to the hospital by (November 18th) February 23, 1951.

7. Result: By this scheme, each hospital will secure the intern considered by it most desirable; and each medical student will receive the

(Concluded on page 104)



it's concentrated*

* Only 1/2 cup to a bucket of water for normal cleaning.

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Just Play a Simple Melody

HOW would you like to have Beethoven, Victor Herbert, or Perry Como, soothe away nervous tension during your next operation? Patients at the University of Chicago Clinics have that opportunity and are benefiting greatly from it. Operating amphitheatres there have been hooked up for recorded music which is audible to the patient but silent to the surgeon.

Music for surgery was first introduced in the University of Chicago Clinics in 1947, as a research experiment, to help alleviate tensions of patients undergoing surgery and was so successful that a permanent installation was arranged. The research was financed by a grant from the United States Navy and the installation, by funds raised by Maurice Goldblatt, president of the University of Chicago Cancer Foundation.

Used with spinal, local, or regional anaesthesia, music is piped to the operating rooms from a central duonetic recorder room, especially designed for the university's medical centre. In the master control room, three duo-channel magnetic tape recorders, each with a different type of music, play continuously for four hours.

To the patient who is to have musical serenading with an appendectomy, vagotomy or other operations where general anaesthesia is not advisable, the music for surgery lessens the patient's apprehension of the pending trip to the operating room. Among the first callers to the patient the night before the ordeal is the anaesthesiologist who asks: "Will you have classical, semi-classical, or popular music with your operation tomorrow?" To the children, he offers music from Cinderella, Peter and the Wolf, Pinocchio, or others of the current favourites.

In the "prep" room, where patients are prepared for surgery, the music of his choice is piped through a mounted loud-speaker on the wall. The soft music lightens the tension but allows the anaesthetist an oppor-

tunity to converse with the patient and to obtain his co-operation during the administration of the anaesthetic. The concert is continued in the operating room for the patient through light-weight stethoscope-type earphones. Only he and the anaesthesiologist who proctors the program hear the music during surgery. So relaxing is the music that the patient frequently exclaims, "Why, is the operation all over?"!

Music for surgery, however, is not a new idea with the University clinics. The practice is as old as Egypt and the incantations of the



pharaoh's physicians. In the Middle Ages, groups of singers were employed by public authorities to soothe the ill during the epidemic manias. Surgeons have reported scientifically in the medical literature on the success of the use of the phonograph and radio in the operating room.

Impetus for the installation at the University of Chicago came from Joel Willard, a young audio-engineer, who suggested that music be used in the operating room to drown out the sounds of the clicking instruments and the conversation of the doctors. First experiments at the hospitals were carried out with a portable wire recorder. In a study of the first 100 patients who heard the "surgical sonatas", the anaesthetists found less than the usual emotional disturbance. This was demonstrated by the action of the patients and by the reduction in quantity of the anaesthetic agents used.

Dr. Lester R. Dragstedt, chair-

man of the department of surgery, commenting on the introduction of music with surgery in the clinics, said: "Both surgeons and psychiatrists appreciate that a surgical operation is a very real and severe ordeal for practically all patients. We are convinced that music which is audible to the patient but which does not disturb the surgeon is a tremendous help in lessening the fear, strain, and tension of the patient." Other surgeons of the clinics stated that the musical adjuvant to anaesthesia relaxed the patients mentally and gave the surgical staff additional freedom in talking, an advantage at the University of Chicago where the full-time surgeons frequently have a group of visiting doctors or medical students observing.

Seventy-eight per cent of the first group of patients queried on the innovation were enthusiastic supporters. Sixty-one per cent of the patients selected semi-classical music, and thirty-one per cent, popular. A small number desired classical and symphonic music and a few wanted popular western folk songs.

Music with anaesthesia is especially applicable to abdominal surgery and it is extremely important in cases where the patient is too old or ill to receive normal amounts of sedation. For peptic ulcer patients, it has been found to be especially helpful since they are already so tense and nervous that the routine medical sedatives are not very effective.

Mechanical Procedure

In the University of Chicago, the mechanics of providing music have been reduced to the simplest procedure. The control room has been designed so that the duonetic tape recorders are self operating, once they have been set for the day. Each recorder, utilizing two recording channels on a 4,800 foot reel of standard one-quarter inch magnetic tape, plays four hours before repeating the program. At the conclusion of two hours playing, a solenoid switch automatically reverses the direction of the tape and places the lower channel in operation.

Wall speakers in the preparation rooms are modernly designed and located near the ceiling. A wall

(Concluded on page 102)

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◀ Provincial Notes ▶

British Columbia

DUNCAN. The King's Daughters' Hospital here will receive a federal grant for the addition of six cots in the children's ward. The government grant will meet approximately one-third of the cost of alterations.

* * * *

ENDERBY. A new 20-bed memorial hospital will be built here. Government approval has been given for its construction provided that the construction cost does not exceed \$90,903.

* * * *

VANCOUVER. Plans for the addition of a 100-bed wing to the Vancouver Children's Hospital are now being drawn up by the architects, Messrs. Gardiner and Thornton, for submission to the provincial government. The new wing will be for the progressive treatment of chronic cases in the hope of rehabilitating these children to an active life. The hospital now has accommodation for 100 patients.

Alberta

CALGARY. The Veterans' Convalescent Hospital here recently held an "open house" for the citizens of this city in order that they might inspect the hospital facilities. The hospital which has accommodation for 150 patients is now providing institutional care, treatment, and occupational therapy, for veterans who served in the South African, First, and Second Great Wars.

* * * *

EDMONTON. The city council's finance committee has approved a

\$2,235,000 modernization and extension program for the Royal Alexandra Hospital. This question will go before the voters at the November civic election and, if approved, it is planned to spend \$1,000,000 for a new 100-bed maternity building; \$1,200,000 for repairs and modernization of the present structure; and \$35,000 for a tunnel to connect the two buildings.

Saskatchewan

MOOSE JAW. A three-week building campaign was launched in this city recently to raise \$62,000 to help finance a new wing for the General Hospital. It is hoped that construction will begin next spring. The new wing will add 144 beds to the present 180-bed hospital.

Manitoba

BALDUR. Recently the new cottage hospital here has been officially opened by Hon. Ivan Schultz, Minister of Health and Public Welfare. The hospital is a completely modern eight-bed unit, with an operating room, case room, nursery, nurses' quarters, kitchen, laundry, and furnace room. The hospital is now in operation under the direction of the matron, Miss Frances Young.

* * * *

ST. BONIFACE. The extension to St. Boniface Hospital, which is to be completed late in 1951, will increase the present total of 384 beds to 679. When the new construction is completed the present north wing, built 73 years ago, will be torn down. A Dominion grant of \$447,000 will be matched by the provincial government.

* * * *

SOURIS. A municipal vote, on October 20, will decide plans for an

addition to the hospital here. The present scheme calls for construction of additional wings and modernization of the present building. A private residence will be enlarged and converted into a nurses' home. In addition, a nursing unit will be built in the town of Hartley.

* * * *

Ontario

FOREST. Authorization has been given to the North Lambton Hospital Fact Finding Committee to procure a charter to build a hospital at an approximate cost of \$210,000. The proposed hospital would serve over 8,000 people in the district. It is expected that the 25-bed building will be located in Forest. The public will be asked to contribute around \$150,000 while provincial and federal grants will be about \$60,000.

* * * *

GRAVENHURST. The Muskoka Hospital for the treatment of tuberculosis here is being enlarged to provide space for 42 additional beds in the east and west wings. This sanatorium, which serves patients from counties in central Ontario and the districts of Muskoka, Nipissing, and Parry Sound, will receive \$52,500 from the federal government, with the remainder of the costs being met by a provincial grant and private donations.

* * * *

KITCHENER. Early completion of the eight and ninth floors of the new Kitchener-Waterloo Hospital is being urged. The two top floors may require an additional outlay of \$260,000 but the difference in grants is \$129,000 if these floors are completed. Since with the completion of the two top floors the hospital will have 372 beds and, coupled with St. Mary's Hospital, will have less than the minimum required in hospital accommodation for the Twin Cities, it is felt that this addition is worthwhile.

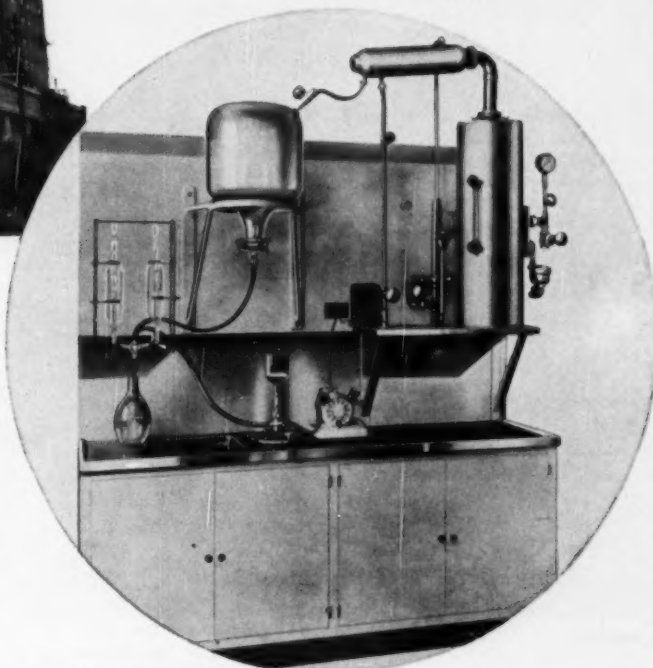
(Concluded on page 68)



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RICHARDS LANDING. Construction of a new wing for the 8-bed Mathews Memorial Hospital here will get under way when plans receive official approval. The wing will be a complete obstetrical unit with four additional beds. This construction has been made possible by a donation of \$10,000 from a former Island doctor, Dr. John E. Godfrey, now of Seattle, Wash., together with several thousand dollars received through public donations.

* * * *

SMITH'S FALLS. It is expected that three units of the new Ontario Hospital-School, which is being erected here, will be ready for occupancy in the spring. The first unit, containing kitchens and six residential pavilions, is complete now and work is progressing well on the remaining two units.

* * * *

SUDBURY. A site for the new Sudbury Memorial Hospital has been purchased. It will be located in the west end of the city and will make hospital facilities readily available in that section. The new site comprises more than 60 acres.

Quebec

CHATEAUGUAY BASIN. A new Julius Richardson Convalescent Hospital will be erected on a new site and the federal government has granted \$181,500 for building costs with the province providing an equal amount. It will have 120 beds for children recovering from various types of illness. The old hospital, under the same name, will be abandoned as outmoded and will probably be torn down.

* * * *

MAKAMIC. The new St. Jean Sanatorium has now been officially opened. The three million dollar hospital with its 225 beds is part of the province's scheme for the development and improvement of the north west district.

MONTMAGNY. L'Hôtel-Dieu de Montmagny is expected to open by July of next year. At that time 60 beds on the third floor will be in use for patients and the departments of general medicine, surgery, and obstetrics will be in operation. The laundry, kitchen, and heating services are expected to be ready for use this fall. Dr. Paul Dupuis will head the Board of Directors for this new hospital which will have accommodations for 118 adults and 32 children.

* * * *

MONTREAL. It is expected that new construction on the Children's Memorial Hospital will begin in the spring. This is being made possible by the success of the Joint Hospital Fund campaign. The proposed new building and reconstruction work will provide accommodation for 250 acutely-ill patients and about fifty long term cases as well as adequate research and teaching facilities. It will contain a modern out-patients department, centrally located for the public, and suitable living quarters for the doctors and nurses.

Nova Scotia

CENTREVILLE. The first sod has been turned at the site of the new St. Elizabeth Hospital which is to be erected by the Sisters of Charity, at an approximate cost of \$1,500,000. Facing the harbour, this new 150-bed hospital will be conveniently located on the highway between North Sydney and Sydney Mines and will service this district.

* * * *

KENTVILLE. Part of the nurses' accommodation at the Blanchard Fraser Memorial Hospital here is to be made over to provide space for 21 additional beds. This will bring the capacity of the hospital to 69. A new residence is being built for the nursing staff. The hospital will receive \$21,000 in grants from the federal and provincial governments respectively.

Library Service at the Queen Elizabeth Hospital

The realization that hospital patients, more than the ordinary individual, need a library service came to the attention of the officials of the Queen Elizabeth Hospital (for long-term patients), Toronto, Ontario, a number of years ago and it is believed that this hospital was the first in Canada to instigate a Public Library service.

Since opening this service, with the assistance of the Toronto Public Library, the hospital has shown an increased circulation from 149 books in 1939 to 9,272 in 1948. Recreational reading has proved invaluable as a therapeutic agent and the excellent results gained from the project have more than compensated for the hard work which was necessary to maintain the service.

A well balanced stock of books chosen by a librarian who understands the background, interests, temperament, and mental capacity of each patient, not only stimulates interest but counteracts apathy and discouragement. Although mystery, adventure, western, and love stories, comprise the greater percentage of books, biography, travel, science, religion, drama, and poetry are not forgotten. Nor does the librarian neglect to select the best books in each classification.—*Annual Report, 1949.*

Former School Becomes Mental Institution

The former De La Salle Training School, at Aurora, Ont., has been converted into a modern hospital-school, for mentally defective patients, by the Ontario Department of Health. This is one more step, by the department, to relieve the serious shortage of accommodation for mental patients.

The new school will have facilities for 250 permanent patients and, already, some 240 have been transferred from the Ontario Hospital, at Orillia. This makes it possible for new cases of mentally defective children to be given the advantage of the special training methods which the Orillia Hospital provides.



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◀ Notes About People ▶

New Appointment at Saint John General Hospital

The Saint John General Hospital, Saint John, N.B., has announced the appointment of Miss Jane M. Stephenson as director of nurses and principal of the school of nursing. After graduating from the Saint John General Hospital, Miss Stephenson specialized in obstetrics at the Royal Victoria Hospital, Montreal, then returned to the General to organize and supervise their first department of obstetrics in 1931. In 1942 she entered McGill University for post-graduate work in hospital and nursing administration. On completion of this course she again resumed her post in the obstetrical department of the Saint John General.

* * * *

Appointed Director of Nursing

The Woodstock General Hospital, Woodstock, Ont., recently announced the appointment of Christina MacCullie, Reg.N., as Director of Nurses. Previously, Miss MacCullie has held the position of Superintendent at Kenora General Hospital, Kenora, Ontario, and prior to her appointment at Woodstock, had been Director of Nurses at the General Hospital, Medicine Hat, Alberta.

* * * *

Alberta Superintendent Retires After 30 Years

Dr. A. H. Baker, superintendent for the past 30 years of the Central Alberta Sanatorium, Calgary, and director of the tuberculosis division of the Alberta Department of Health, retired at the end of September.

After graduating from McMaster and the University of Toronto, Dr. Baker served with the Voluntary Imperials (C.A.M.C.) during World War I. Then in 1920 he became superintendent of the Central Alberta Sanatorium.

He is a fellow of the American College of Chest Physicians; a fellow

of the Royal College of Physicians and Surgeons of Canada; a member of the Mayo Clinic Former Staff Doctors' Association; and a member of the Calgary Medical Society.

Dr. Baker plans to continue work in the tuberculosis field after his retirement.

* * * *

Dr. J. H. Quastel to Direct Institute

The Montreal General Hospital has appointed Dr. J. H. Quastel as director of their Institute for Special Research and Cell Metabolism. Dr. Quastel was formerly associate director of the institute and is also professor of biochemistry at McGill University. A graduate of Cambridge University and the University of London, he joined the institute in 1947 as associate director. Dr. Quastel will succeed the former director, Dr. I. M. Rabinovitch, organizer of the institute, who is retiring to devote his time to practising as a consultant in diabetes and toxicology.

* * * *

Miss J. M. Weir to Direct Nursing School at Queen's

Queen's University, Kingston, Ontario, has announced the appointment of Miss J. M. Weir as director of its School of Nursing and also assistant professor of public health nursing. For the past year she has been acting director of the school and lecturer in public health nursing.

Miss Weir, who is a graduate in nursing from the University of Alberta, holds a diploma in public health nursing from the University of British Columbia and a Master of Arts degree in supervision and public health from Columbia University, New York. She served with the R.C.A.F. as a nursing sister during the war and, after study at Columbia University, went to Queen's in 1947.

Queen's has also appointed Miss Evelyn Moulton as lecturer in nursing

education. Miss Moulton, formerly supervisor at the Ontario Hospital, Kingston, is a graduate of Queen's School of Nursing and of the University of Toronto.

* * * *

Superintendent Retires

Miss Mabel Wray, superintendent of the Listowel Memorial Hospital, Listowel, Ontario, has resigned owing to ill health. Miss Wray had been superintendent of the hospital for four years and prior to this had served at the Louise Marshall Hospital, Mount Forest, Ontario. Her position will be temporarily filled by another member of the nursing staff until a successor is appointed.

* * * *

Administrator Appointed for Humber Memorial Hospital

Gordon Smith of Hamilton, Ont., has been appointed administrator of the new Humber Memorial Hospital at Weston, Ont.

Chief pharmacist at the Hamilton General Hospital since 1944, Mr. Smith has made a thorough study of administration as applied to certain departments and to the hospital as a whole. He assumed his duties last month at the new hospital, which is expected to open shortly.

Mr. Smith will continue as business manager of the "Hospital Pharmacist" journal and chairman of the Advisory Council of the Canadian Society of Hospital Pharmacists.

Omission

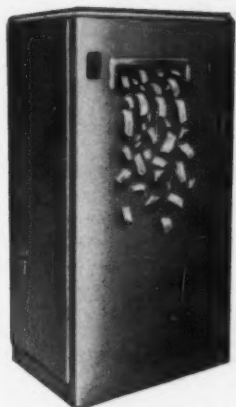
In the June issue of this journal, page 36, there was published an article on the new pavilion at Charlottetown Hospital, Charlottetown, P.E.I. In this connection, our attention has been drawn to the fact our information was incomplete with respect to the architects concerned in the project. The architect for this building was Mr. James E. Harris of Charlottetown, with Mr. E. S. Blanchard, also of Charlottetown, and the firm of Govan, Ferguson, and Lindsay, Toronto, acting as consultants.

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Soda Fountains: The Ice Cube Maker ensures a plentiful supply of sparkling ice cubes. No waste during slack periods—delivery is controllable.

Hospitals: Without mess or waste, the Ice Cube Machine makes pure ice cubes for use in water and cooling fruit drinks for patients . . . automatically, day or night.



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What Do You Know About Fish?

TO a relatively small group of Canadians, the three per cent (approximately) of the population engaged in the fishing industry, fish and fishing are very important subjects. To Canadians in general, however, these are subjects that are given little thought. Although meat and fish are considered interchangeable for practical nutritional purposes, the consumption of the former in Canada for 1948 was estimated at 135.3 pounds per capita, while that of the latter was only 12.2 pounds.

A recent study of regional consumption of fish in Canada brought out some interesting aspects of Canadian tastes in this regard. More canned fish than fresh or frozen, is eaten. It accounts for 53 per cent of consumption, fresh and frozen for 37 per cent, smoked and cured for 8 per cent, and shellfish for 2½ per cent. Quebec and Ontario, with 62 per cent of the Canadian population, together consume more than 60 per cent of the fish eaten. On the other hand, the amount eaten in the prairie provinces is considerably less although Manitoba and Saskatchewan are the chief users of inland fish.

Some interesting regional preferences were also brought out. Shellfish make up 20 per cent of the fish consumed on Prince Edward Island as compared with about 6 per cent in other regions. Lobster constitutes a large part of the shellfish eaten by the islanders who use more canned lobster, proportionately, than any other group. Oysters are popular among all Maritimers. In Nova Scotia, cod is the favourite fish. In fact, it generally leads consumption of fresh and frozen fish with salmon second, haddock third, and halibut fourth.

Canadian consumption by no means accounts for all the fish produced from Canadian waters. In fact, approximately two-thirds of the catch is marketed outside the coun-

try, the United States buying about 70 per cent of the exports. Because of the relatively small domestic market, most Canadians are not familiar with the regulations governing inspection and grading of fish. As a matter of interest, these are summarized briefly here. Under the *Meat and Canned Foods Act* there are regulations, administered by the Minister of Fisheries, governing the inspection of canned fish and shellfish. On the Pacific coast, all canned salmon and canned herring packed in British Columbia must be inspected and found to comply with established standards before being released for sale on Canadian or foreign markets. On the Atlantic coast, standards of quality and grades have been established for some canned fish and shellfish. Firms of a certain size or larger may obtain permits that entitle them to the services of an inspector to grade their packs.

Under the *Fish Inspection Act* there are regulations governing the construction of containers, the curing and packing of fish, and the inspection thereof. These are administered by the Minister of Fisheries and apply only to fish that is to be exported. These regulations ensure that cured, salted, pickled, or smoked fish being sold outside Canada meet specified standards, represented by grades. Thus quality is maintained.

It should also be mentioned that under the Fisheries Act there are regulations governing the lobster fishing industry in the provinces of Nova Scotia, Prince Edward Island, New Brunswick, and Quebec.

No grades have been established for fresh or frozen fish. This is understandable when the fundamental point is recognized. Fresh fish must be fresh. There is, therefore, only one possible classification.

In the past it was not always possible to transport fish from its source to the large centres of population with sufficient despatch to maintain the essential quality-freshness. Consequently a very large proportion of Canadians have not had

the opportunity to taste the fine flavored fish so highly regarded in the coastal provinces. This is probably the chief reason why domestic consumption of fresh fish has remained low. Modern developments in transportation and refrigeration, accompanied by improved marketing practices, are now altering the situation.

There are more than 70 varieties of fish and shellfish available to the Canadian consumer. All may be considered interchangeable with meat from the nutritional point of view, being excellent sources of animal protein and rich in certain other nutritive elements. There are, of course, variations in the nutritive values of different types of fish—some, for example, contain a larger proportion of fat than others. Other differences may be illustrated by the following remarks based on examination of the nutritive values of a few types of fish. Canned salmon, lobster, oysters, and smoked herring are good sources of calcium while oysters also have a high iron content. Fresh salmon and oysters contain more thiamine than most meats, the exceptions being pork and organ meats.

Regardless of the variety being purchased, the consumer should keep the following points in mind when buying fresh fish. The eyes should be bright, clear, full, moist, and not wrinkled or sunken; the flesh should be elastic and firm; the gills should be fresh in colour; the scales should cling tightly to the skin and have a sheen; and the natural colour of the fish should be bright and clear, not faded. Since all fish is tender, the time allowed for cooking should be just long enough to develop flavour and make it palatable.

A Word of Advice

When you've got a thing to say,
Say it! Don't take half a day.
When your tale's got little in it,
Crowd the whole thing in a minute!
Life is short—a fleeting vapour—
Don't you fill the whole blamed paper
With a tale which, at a pinch,
Could be cornered in an inch!
Boil her down until she simmers,
Polish her until she glimmers.

—Joel Chandler Harris.

Reprinted from "Canadian Nutrition Notes" published by the Department of National Health and Welfare, Ottawa, Sept., 1950.

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Designed along good modern lines and especially constructed to meet the requirements of an interior hospital door. The stiles are 4 1/2" wide, reinforced to 7 1/2" to provide for the installation of push plates and lock assembly. The bottom, centre and top rails are 9" high to provide for "Kick-Plates", "Door Holders" and "Tray Hook".

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Here and There

The Unwary Beware

At length I rejoined the 66th at Fuentes del Maestro,* just in time to accompany it on the advance of the Division in the direction of Llerena; but, on some intelligence being received of the concentration of a strong force of the enemy on our right, the Division was countermarched, and our Brigade, consisting of the Buffs or 3rd Foot, the 31st, 57th, and 66th, returned to their old quarters at Fuentes del Maestro.

The day of our return was hot, and the road had been very dusty, with a good deal of wind. When the Brigade reached the immediate neighbourhood of the town, they halted and piled their arms until the men were furnished with billets. Near this spot was one of the old fountains from which the place had taken its name, which was a square enclosure, now in ruinous state, and half filled with grass and weeds, but still containing clear water. The thirsty soldiers, fatigued with the heat and long march, flew at once to this reservoir, and kneeling and placing their hands on the low wall that surrounded it, they dipped their dusty muzzles up to the ears in the cool element and quaffed away like fishes.

"The consequence was awful in the extreme."

Next morning about one hundred and fifty of them came to the different regimental hospitals, and at first their cases looked rather alarming, for they were all spitting blood. On examination it was ascertained that they had fished up three or four hundred leeches from the old fountain, which was full of these little wretches. These blood-suckers had attached themselves in the mouth, nostrils, throat, gullet, and even the stomach; higher or

lower, according to the vigor of their own adhesive powers, or the strength of suction of the drinkers. We had a bloody day at the hospitals, although no lives were lost, except the leeches, and very hard it was to eject them. Some were noosed with a silk ligature by the tail and torn off, though many were thus cut in two, leaving the head still sticking. Several were dislodged by a strong solution of salt, and tobacco was used to others. Powerful emetics were necessary to oust the knowing ones that had reached the citadel of the stomach. At last the enemy were finally beaten from all positions with great slaughter.

A Fellow Can't Even Have Fun

The Associated Press recently carried the following story[†] under a London, England, dateline: "It was reported that eleven year-old Bill, who lost an eye in an accident, turned up at school minus his glass optic. He confessed that he had used his glass eye, plus his emergency spare, to play marbles with friends. He broke both. The National Health Service is providing him with another glass eye and has made the proviso that he keep it in its place and does not roll it around the playground."

Kitchen as Big as Victoria Station

From comments by a British Nurse who worked for a time this year in a Canadian Sanatorium:

"Night nurses take it in turns to cook the midnight meal for the night staff, and the engineers who are on duty in the boiler-house. This cooking is done in the sanatorium kitchen and is a somewhat terrifying experience for the newcomer. I used to feel that I would rather cope with a dozen cases of hemorrhage than be at the mercy of these enormous stoves in a kitchen which seemed as big as Victoria Station, but I soon grew accustomed to it, and after the

privations of Britain there was a feeling of glorious abandon in cracking a dozen or more eggs into a sizzling pan, or in simply contemplating a dish full of juicy steaks."—*Nursing Mirror and Midwives Journal*, London, Eng., April, 1950.

Gift of Persuasion

An American philanthropist, Robert E. Stevenson, succeeded in persuading Canadian Customs officials to allow his latest gifts to Victoria Hospital, London, Ont., to come through duty-free. The gifts, three gleaming, highly-polished, handmade writing desks, were presented to the nurses for use in their residence.

Two years ago, Mr. Stevenson, a retired Michigan farmer, gave the Victoria Hospital \$3,000 because he had heard that it was "one of the best hospitals in Canada". Since that time Mr. Stevenson has shown an active interest in the hospital and, because of his benevolence, the library in the nurses' residence is known as the Stevenson Library.

* * * *

Building Blues Banished

When opening day came for the lovely new Alexandra Hospital in Ingersoll, Ont., thousands cheered as Lieutenant-Governor Ray Lawson cut the ribbon at the front door during the jubilant ceremonies. It was a big moment for all those who had contributed time, money, and effort, for eight long years. As A. R. Horton, chairman of the civic building committee so aptly expressed it, "the hospital was a dream for several years, a nightmare one year ago, and today a glorious reality".

Duck shooting is the most elaborate and rigorous preparation for an excuse to take something to warm you up that has ever been invented by man.—T. R. Henry.

*During the Spanish Campaign in the Napoleonic War. An excerpt from "Trifles from my Port-folio", by Dr. Walter Henry.



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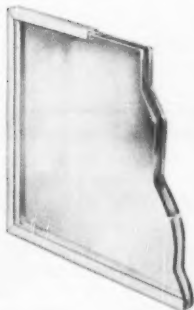
*Architect: David Finch and Associates, Winnipeg.
Contractor: Peter Leitch Construction Ltd., Winnipeg.*

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◀ Book Reviews ▶

A HISTORY OF THE MONTREAL GENERAL HOSPITAL. By H. E. MacDermot, M.D., F.R.C.P. (C.), Editor of the Canadian Medical Association Journal and member of the staff of the Montreal General Hospital. Pp. 124. 16 Illustrations. Price, \$2.50. Published by the Montreal General Hospital, Montreal. 1950.

This well-illustrated and comprehensive "biography of a hospital" is a fine example of what should be done for more hospitals situated in other locations across Canada. It is a neat little volume that will bring an evening or two of enjoyment as well as an interesting lesson in history.

It begins with the strivings of a growing city to extend its hospital facilities, efforts which culminated in the opening of the original building (a large house) on May 1st, 1819. The unselfish contributions of its governors through the years have left a true heritage to present-day trustees, a prime example to trustees everywhere. It is interesting to note that frequent hospital visits by governors were considered advantageous at this early date. Throughout the early development is also woven the

formation of the Faculty of Medicine at McGill University.

Of necessity this book deals largely with people and their vagaries, rather than with equipment and other such material things. This adds to its interest a good deal. At one point, because of community complaints about discharging the aged and infirm from hospital, it was reported, "It is only necessary to observe that the Hospital was erected for curing the sick, not for maintaining the poor." Is this problem not still with us? This frequent use of quotations directly from original sources greatly enriches the book.

The medical staff receives a good deal of attention throughout the book. For the hospital reader unfamiliar with McGill, however, these sections may lose interest.

This little bit of history will leave the reader encouraged and hopeful, for many problems that seemed insurmountable at the time were met successfully during the years, just as today's problems will be answered. And the narrative closes with the decision to build an entirely new hospital on a new location—almost a clean break to start the next volume of the Montreal General's story. ●

Evacuation Peacetime

(Concluded from page 35)

ment and casualty service will continue and typhoid inoculations will proceed as before. I have also taken the liberty of offering the use of facilities there (as long as they are available) for the care of contagious diseases, since such cases would otherwise have to be ferried into the King George from somewhere on Morely Avenue. Only a small number of patients is expected and, if our building can no longer be heated or served with power or becomes surrounded by water, plans are being made to provide isolation facilities at the Central Tuberculosis Clinic.

"Incidentally, the day following our move to Red Cross Lodge, because of the large number of extra cribs available with so many of our patients placed in foster homes, we were able to accommodate twenty of the more seriously handicapped pa-

tients from the Shriners' Hospital, while preparations were being made to move that hospital to Regina. We have also been able to help other hospitals by lending twelve cribs to the Winnipeg General, two incubators to Grace Hospital, and eleven cribs with mattresses to equip the temporary nursery set up in the Winter Club by Surgeon Lt. Commander MacNeil, who has been called back temporarily into the navy from our pathology department.

"It has been extremely satisfying to me to see how efficiently our staff operates in a crisis and how generously assistance is offered by members of our board, guilds, honorary attending medical staff, and others with an interest in the hospital. It is satisfying, too, to know that we are the only hospital, temporarily emptied of its patients, which is carrying on, practically self-sufficient, in new quarters."

Return Journey

The return to our hospital, after all danger from the flood was over, was not nearly so dramatic as the evacuation; no cold, rainy night, no high excitement with the possibility that Winnipeg would have to be completely evacuated as the Army had warned, and no high tension. There was just weariness, boredom, and irritability at lack of proper facilities, and the hope that soon we could settle down again to a job where we belonged.

Our return was even better organized than the evacuation. Patients, under the care of nurses, were moved in cars, offered by members of the Board, directly to the hospital where beds and cribs had been set up. Beds, stretchers, food, emergency equipment, et cetera, were transported in large trucks readily supplied by various breweries in the city. The project was accomplished with the wholehearted co-operation of volunteer workers from the service clubs of Winnipeg. We started at 4.45 in the afternoon and by 7 p.m. all patients were settled and equipment set in place. By then, too, weary volunteers were being refreshed with hot coffee and sandwiches.

In this time of stress, much credit must be given to the staffs of all hospitals who carried on, giving the best service possible even when many of their own homes were in danger of being flooded, or were then under water. The spirit of service, always present in any hospital, was most clearly evident at this time.

While we were particularly proud of our own hospital, we are not forgetting the hundreds of hospital people who laboured unselfishly, who either evacuated or received evacuees. Praise, too, must be given to many of the nurses who voluntarily gave up their holidays to travel to all parts of Canada with the trainloads of sick and bewildered who had been forced to leave the homes they had known all their lives.

The flood, or should I say FLOOD, was worse and more destructive than it is possible to describe. But Manitoba and its people showed that it takes much to defeat them. As yet, that "much" has not occurred.

NEW non-caloric
sweetener stays sweet
... even in cooking,
baking, canning



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● Non-caloric sweetener for restricted and low calorie diets

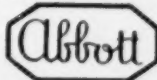
With SUCARYL Sodium, Abbott's new non-caloric sweetening tablets, patients on restricted or low-calorie diets will have immeasurably greater freedom in menu-planning — for now even those foods prepared by **cooking, baking or canning** can be sweetened without adding forbidden calories or carbohydrates.

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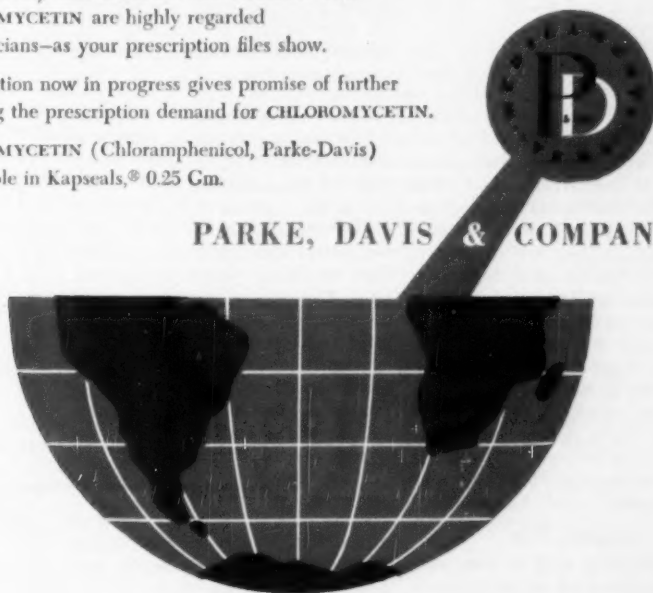
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PARKE, DAVIS & COMPANY



The Medical Staff

(Continued from page 38)

mainly to lack of understanding. If doctors are thoroughly aware of why the medical staff is organized in the manner it is, they will accept the regulations graciously and endeavour to see that they are carried out.

The question of when medical appointments should be made and how long they should last is very important. It is my opinion, and I feel quite strongly on the matter, that these should be made annually and that all staff appointments should terminate at 65 years of age.

The advantage of a system of annual appointments is that it helps to make the doctor aware that continuation of his appointment depends on satisfactory service. This keeps him constantly alert to the best interests of the hospital. If your by-laws state that all staff appointments terminate at 65 years of age you avoid the embarrassing situation which occurs when a doctor reaches the age at which he is no longer active and yet does not wish to relinquish his appointment.

Divisions of Staff

While there is some leeway permissible in the matter of medical staff groups, we have found that the best division is as follows:

1. Emeritus Staff.
2. Consulting Staff.
3. Active or Attending Staff.
4. Associate Staff.
5. Courtesy Staff.

Emeritus Staff

In this grouping are those, who by virtue of previous service to the hospital, warrant being retained on the staff and yet who have reached the age where they are no longer active. No medical staff feels like removing an individual who, by virtue of long service, has reached an honoured and revered position. As a member of the emeritus staff such a person can be placed without hurting anyone's feelings. This group should not have voting privileges but should be encouraged to speak at staff meetings as their advice is often valuable.

Consulting Staff

The consulting staff is composed of doctors who have special degrees and qualifications which place them in a consulting capacity. At a

minimum, they will be certified specialists of the Royal College of Physicians and Surgeons of Canada, and should have additional qualifications as well. In our hospital they are limited to those specialists who do not work actively in the hospital but who do see cases here in consultation.

The Acting or Attending Staff

This group is the backbone and heart of your hospital. It consists of specialists and experienced general practitioners who are actively engaged in daily practice in your hospital and who have the interest of the institution at heart. I do not think that the attending staff should be too large. It should contain those doctors whose patients continuously occupy a large number of beds in your hospital. These doctors should be active in all the clinical work of the hospital, must attend 75 per cent of staff meetings, ward rounds, and other clinical gatherings. They must be prepared to assume responsibility in the field of administrative matters and must generally be prepared to give time and energy to support the hospital. It is especially important that "dead wood" be not allowed to accumulate on your attending staff; and that once a man shows lack of interest, he should be immediately transferred. All appointments to standing committees should be made from this group.

Associate Staff

This division should be limited to new members who are progressing towards the attending staff. They should be encouraged to attend all staff meetings, to assist with teaching nurses and interns, and should show an active interest in the hospital. The work of this group should be constantly supervised by department heads and also by the medical superintendent. Therefore, when the time arrives, a decision may be readily reached as to whether doctors in this group are suitable for transfer to the attending staff.

Courtesy Staff

In this classification are members of the staff who visit your hospital only occasionally. They usually comprise a large group. They are not expected to attend staff meetings or ward rounds regularly and usually

have a more active interest in other hospitals.

Attending or active staff, by virtue of the time given to the hospital, should have priority on admissions at times of stress, as for instance during the months of January, February, and March. This has been a controversial point and has been objected to frequently and strenuously at our hospital, but I think it is only fair that the attending staff should receive some compensation for the time given to the welfare of the hospital.

Officers of Staff

The executive officers of our hospital are the chairman, vice-chairman, and secretary-treasurer who are elected annually. The chairman presides at all staff meetings and virtually acts in the capacity of chief of staff while the vice-chairman acts in the absence of the chairman. The secretary-treasurer is responsible for keeping a proper record of the transactions of all staff and executive meetings, together with the record of all members present.

Heads of Staff and Alternates

The matter of appointment of heads of staff depends to a certain degree on the size of the hospital and the extent and activity of the different departments. We have at our hospital a head of staff and an alternate for medicine; surgery; obstetrics and gynaecology; anaesthesia; paediatrics and infectious diseases; eye; ear; nose and throat; orthopaedic surgery; and genito-urinary surgery.

The heads of staff and alternates are elected annually. In addition to them, there are other members of the staff who assist with the duties of the division. In actual practice, all of this group are nominated by the nominating committee, passed on by the executive committee, and voted on by the whole staff, annually. The head of staff, or his alternate in his absence, should be responsible to the superintendent for the work of that division. This is a responsibility that is often difficult to instil in heads of staff. I feel that if these heads are to function properly they must be prepared to undertake the responsibility of disciplining the other members of the

(Concluded on page 106)

One of a series of reports on

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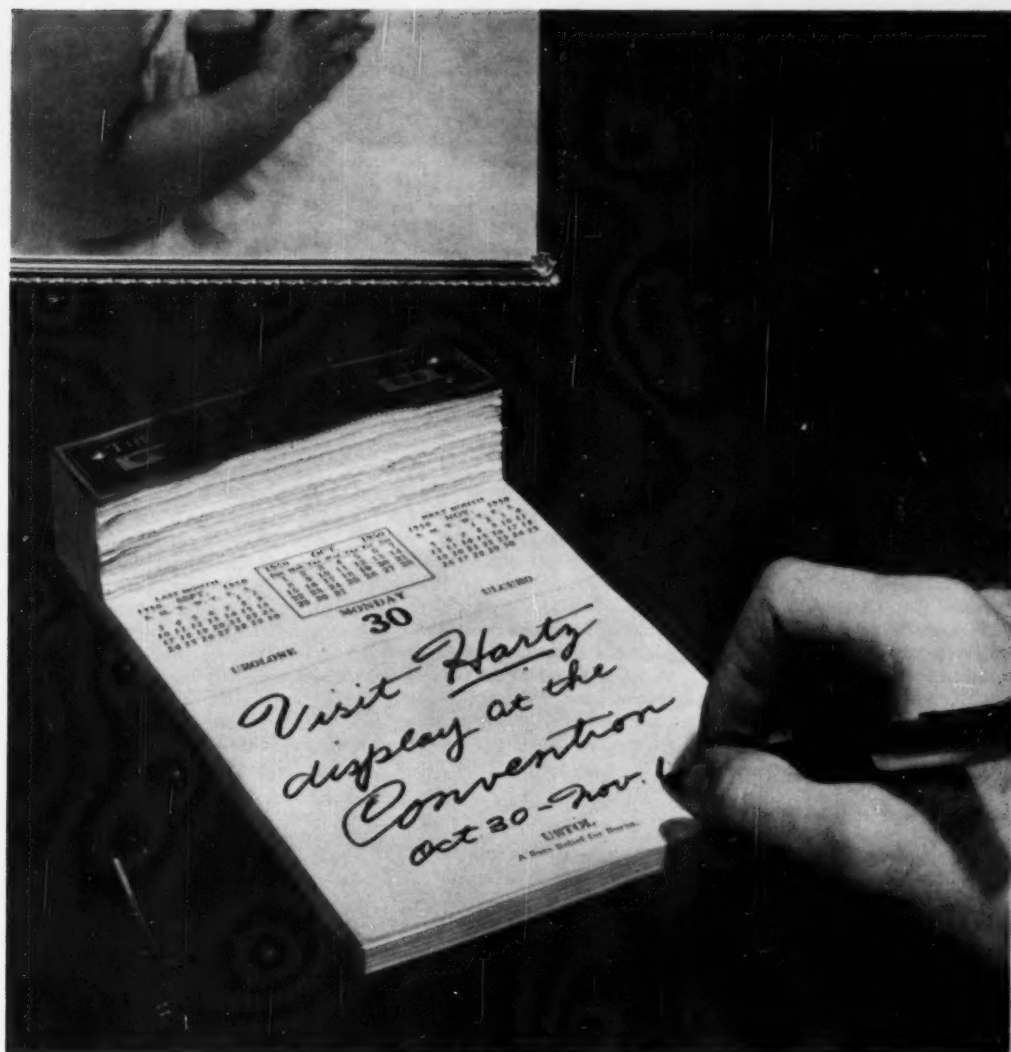


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L'Organisation Hospitalière

(Suite de page 40)

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Vous noterez que le plancher de tuiles quadrillées n'est pas inclus.

Tout, dans la salle, doit être relié au plancher. Si vous voulez avoir des détails sur cette question, je vous renvoie à la brochure No. 56, intitulée *Recommended Safe Practice for Hospital Operation Room*, 1949, acceptée par la N.F.P.A. et la N.B. of F.U. Elle se vend au prix de 25c. et on peut se la procurer en s'adressant à la N.F.P.A., 60 Battery Street, Boston 10, Mass.

Un mot d'avertissement: faire les choses à moitié sous ce rapport est inutile; de plus, même en prenant toutes les précautions voulues, il faut surtout que le personnel de la salle d'opération soit en constant état d'alerte devant le risque d'explosion.

A la suite des rapides progrès de la science chirurgicale et d'une meilleure appréciation des techniques aseptiques, les plans des salles de chirurgie se sont améliorés. Les hôpitaux de 150 lits et plus devraient inclure dans leurs plans une salle de rétablissement située dans les pièces réservées à la chirurgie. Un personnel expérimenté surveille les malades pendant la période critique; l'oxygène et l'appareil aspirateur sont à portée de la main et, en cas d'urgence, il est facile de mander l'anesthésiste.

Approvisionnement Central

Un endroit central réservé à la stérilisation des accessoires de tout l'hôpital donne de meilleurs résultats, car le personnel qui s'y trouve est spécialisé dans cet ouvrage. La responsabilité se trouve concentrée dans un même endroit, et on économise sur le matériel d'autoclave, qui est dispendieux. Il convient qu'un centre de stérilisation et d'approvisionnement soit contigu aux salles de chirurgie, car c'est ce département qui emploie le plus d'articles stérilisés. On fabrique maintenant des autoclaves avec parois isolées, ce

qui permet de ne pas les enchâsser dans les murs.

Un des plans les plus récents de ce service, prenant exemple sur l'industrie, place le bureau de l'infirmière responsable dans un endroit central, d'où elle peut voir et surveiller toutes les opérations du département. On recherche en ce moment le moyen de fabriquer un équipement qui permettra à cette infirmière de surveiller de son bureau, entièrement et directement, toutes les opérations des autoclaves.

Nouveaux Matériaux

On a découvert, au cours des dernières années, de nouveaux matériaux de construction, surtout en ce qui regarde le fini.

L'industrie du bâtiment a connu, au cours des âges, une longue et lente évolution, alors que de nouvelles méthodes sont venues se greffer sur le recours traditionnel aux matériaux et méthodes de base. L'emploi de solives préfabriquées de nouveaux métaux, de béton léger, de planches murales, de panneaux en contreplaqué, de verre et de plastique de construction est, dans tous les cas, de date assez récente dans

l'industrie du bâtiment, bien que nous les regardions, à l'heure actuelle, comme d'usage courant.

Risques d'incendie

Il y a ensuite le progrès accompli dans le domaine des peintures ignifuges, qui sont très bonnes et qui ont décidément leur place dans tous les petits hôpitaux qui ne sont pas à l'épreuve du feu.

Il n'est pas nécessaire que j'insiste auprès de cet auditoire sur les risques d'incendie dans nos hôpitaux, quand vous avez encore présents à la mémoire des incendies comme ceux d'Effingham et du Mercy Hospital de Davenport, Iowa.

L'idéal, c'est une construction résistante à l'action du feu, tout en prenant le moyen de découvrir un incendie à ses débuts et de le combattre avant qu'il ait fait des progrès. Il faut ensuite une méthode sûre de déménager les malades si l'incendie devient incontrôlable. Il est aussi très important d'installer dans les hôpitaux des coupe-feu, surtout pour préserver les appartements des malades de la fumée et de la chaleur. Un bon système de gicleurs, surtout dans le sous-sol, où les incendies sont susceptibles d'éclater, est une grande protection. Il devrait y avoir au moins deux issues distinctes à chaque étage et dans chaque section distincte d'étage, et les escaliers intérieurs devraient être isolés et construits de matériaux résistants à l'action du feu.

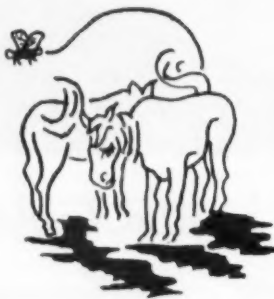
Il y a à l'heure actuelle, sur le marché, plusieurs excellents systèmes d'alarme actionnés par la chaleur qui vous aideront à assurer aux malades la protection voulue. Vous ne voulez pas vous permettre de risquer leurs vies. On a fait beaucoup de progrès en ce qui regarde le matériel de lutte contre l'incendie, mais ce qui importe surtout sous ce rapport, c'est que le personnel de l'hôpital surveille toujours les risques possibles d'incendie.

Oxygène

Un hôpital moderne devrait avoir une canalisation d'oxygène. Une installation de ce genre paiera ses frais avec les années, en économisant le gaz ainsi que la main-d'œuvre obligée de transporter de lourds cylindres d'un bout à l'autre de l'hôpital. Elle élève le coût initial de la construction, mais elle écono-

(Suite à la page 92)

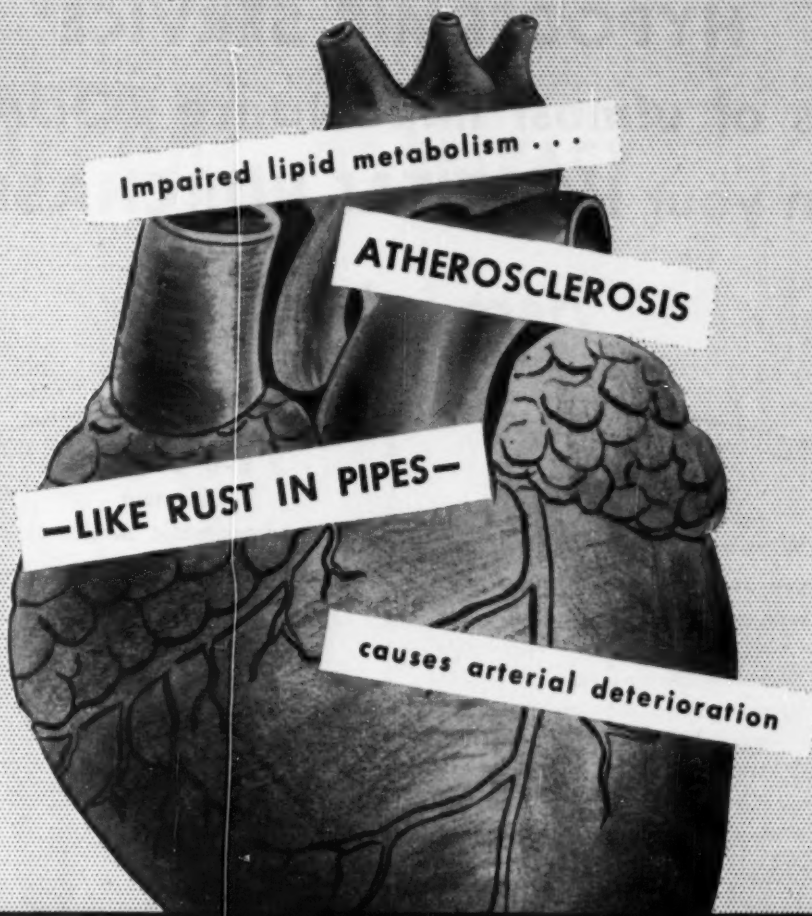
Horse Sense



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L'Organisation Hospitalière

(Suite de page 88)

mise les frais d'exploitation dans une mesure telle que, au bout de quelques années, l'argent épargné aura défrayé le coût de la canalisation.

Je recommanderais une canalisation d'oxygène dans les endroits suivants: salles d'opération et d'accouchement; salles de rétablissement; pouponnière de prématurés et de suspects; département des cas d'urgence; et certaines salles, spécialement celles de médecine et de pédiatrie.

On devrait établir un endroit central d'aspiration dans les salles d'opération et d'accouchement, les salles de rétablissement; le département des cas d'urgence; les pouponnières de prématurés; le département d'oto-rhino-laryngologie, et les laboratoires.

Tubes Pneumatiques

L'efficacité d'un hôpital dépend, en grande partie, de la minutie et de l'exactitude de travaux de bureau qui doivent être transmis d'un département à l'autre. L'installation d'un système de tubes pneumatiques, surtout dans nos hôpitaux les plus importants, constitue un service rapide et fiable de commissionnaire qui épargne au personnel du temps et du travail.

Lampes Ultra-violettes

On a beaucoup discuté sur l'utilité et le danger de recourir aux lampes ultra-violettes pour réduire les miasmes qui flottent dans l'air, surtout dans les pouponnières. Il est intéressant de souligner ce qu'on a décidé sous ce rapport au nouvel hôpital pour enfants malades, à Toronto. On continuera à cet hôpital, dans le cas des jeunes enfants jusqu'à l'âge de deux ans, de traiter chaque cas individuellement.

Les salles de ce groupe d'âge sont divisées par des cloisons de 7 pieds qui descendent jusqu'au plancher et dont la partie supérieure est vitrée. Les lampes germicides ultra-violettes sont installées sur le dessus des cloisons et jettent des rayons horizontaux dans l'espace supérieur du compartiment, tandis qu'une autre lumière située en haut de la porte jette un rideau de lumière de haut en bas de la porte. On a mis ce système à l'essai dans cet hôpital, avec le résultat que, dans les endroits

où ces lampes sont installées, la fréquence de l'infection par contamination est deux fois moindre que dans les endroits non protégés.

On emploie également ces lampes dans les réfrigérateurs afin d'empêcher la formation de moisissures sur les aliments. Une installation de ce genre que j'ai vue au Bethesda Naval Hospital de Washington donne de bons résultats.

Département de la Diététique

Enfin, j'aimerais à dire un mot sur le progrès que l'on a réalisé pour assurer une bonne nourriture aux malades et aux membres du personnel.

On admet qu'il est de première importance de dresser les plans de la cuisine en fonction de l'emplacement du magasin, des salles à manger, et du transport rapide aux garde-manger des salles. Le tracé des plans de la cuisine, que l'on divisera en fonction des diverses phases de la préparation des aliments: cuisson, réfrigérateurs, lavage de vaisselle, récurage des casseroles, bureaux des diététiciennes et succursales du magasin, est aussi d'une très grande importance. Si l'espace alloué est trop étroit, il y aura inefficacité et sautes d'humeur; s'il est trop vaste, il y aura gaspillage de temps et d'énergie.

Aujourd'hui, dans le plan des cuisines d'institutions modernes, on trouve moins de compartiments, plus de lumière naturelle et d'aération, ce qui facilite la surveillance. On réserve moins d'espace pour les régimes spéciaux, car il y a tendance à utiliser davantage les aliments ordinaires et à rapprocher le plus possible les régimes spéciaux des régimes normaux.

On se sert de plus en plus de métaux inoxydables pour les fours, les réfrigérateurs, les fourneaux à vapeur, et cetera. La mode est au matériel aux angles arrondis et aux pattes tubulaires ajustables. Les manufacturiers fabriquent sans cesse du nouveau matériel afin d'aider à préparer les aliments de la manière la plus efficace possible.

Au récent congrès de la National Restaurant Association, à Chicago, on a montré un grand nombre de nouveaux articles d'équipement, par exemple:

(a) des fours tournants qui distribuent la chaleur plus également;

(b) des bouilloires à vapeur complètement recouvertes, qui donnent un meilleur rendement, avec une pente intérieure qui facilite l'écoulement;

(c) des autoclaves à vapeur automatiques dont chaque compartiment est contrôlé par un chronomètre électrique;

(d) une nouvelle sorte de laveuse de vaisselle mécanique qui, au lieu de paniers, a une courroie sans fin; les plats sont séchés à l'air et ensuite retirés de la courroie;

(e) une nouvelle laveuse et sécheuse entièrement automatique pour l'argenterie, qui lave, rince, stérilise et sèche. En 3 minutes et demie, elle complète toute la besogne.

On nous a montré une nouvelle sorte de poêle-combinaison; une machine à nettoyer la batterie de cuisine, mue à l'électricité; un écailleur électrique de poissons et jusqu'à une machine pour faire les petits pâtés à la viande, au taux de 20 à la minute, tous de 4 pouces de diamètre.

Il y avait aussi des nouvelles sortes de chauffeplats à chaleur radiante pour les cafétérias, des wagonnettes chauffées pour le transport des aliments cuits, des fontaines à café et des tables pour le transport des plats chauds. Ceux qui fabriquent ce genre de matériel, aiguillonnés par la concurrence, s'efforcent sans cesse de produire un meilleur outillage; aussi constatons-nous du progrès dans ce domaine particulier des besoins hospitaliers.

Radiologie

A la suite de l'augmentation spectaculaire des tensions dans le domaine de la thérapeutique radiologique et de l'utilisation des isotopes radioactifs pour le traitement médical, la protection contre les effets malfaisants de la radiation constitue un problème de plus en plus important. Afin d'éviter le haut coût de cette protection, il faudra peut-être installer sous terre les départements de radiologie.

Il est difficile de prévoir quels seront, dans l'avenir, les besoins de la radiologie. On trouvera peut-être le moyen de guérir le cancer, ou le moyen d'utiliser d'autre façon la thérapeutique radiologique, ainsi que les isotopes radioactifs. Dans

(Suite à la page 105)

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Galatest and Acetone Test (Denco) . . . Spot Tests that require no special laboratory equipment, liquid reagents, or external sources of heat.

One or two drops of the specimen to be tested are dropped upon a little of the powder and a color reaction occurs immediately if acetone or reducing sugar is present. False positive reactions do not occur. Because of the simple technique required, error resulting from faulty procedure is eliminated.

Both tests are ideally suited for office use, laboratory, bedside, and "mass-testing". Millions of individual tests for urine sugar were carried out in United States Armed Forces induction and separation centers, and in Diabetes Detection Drives.

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◀ Health Care Plans ▶

Blue Cross-Blue Shield in the Maritimes

The 1949 Annual Report to the Maritime Hospital Service Association by the chairman, Dr. Joseph A. McMillan, showed that last year the Maritime Blue Cross paid its hospitals \$2,007,314.00 and, in the short time that the Blue Shield Division has been in operation, \$292,593.00 has been paid toward the cost of surgical, obstetrical, and medical care.

The year 1949 again showed an increase in the utilization of the plan over the previous years. In 1947 there were 123 for every thousand exposed persons who used the service. In 1948 this figure rose to 138 and last year it reached 148. Although the average length of stay remains relatively fixed at about 8.77 days per case, the average cost has increased about 25 per cent for 1949 over the costs for 1947.

Concerning the problems of increased costs, Dr. McMillan stated in his report, "We must attempt to balance our hospital costs against our subscriber income and this means very close scrutiny of all hospital claims and a public relations program to inform all our subscribers and our doctors of the absolute necessity of keeping costs, particularly extras, within absolutely necessary limits."

Dr. McMillan also welcomed our new sister province, Newfoundland, to the Maritime plan. That province is now represented on the board by Dr. Harry D. Roberts of St. John's.

* * * * *

Community Program

To aid the Hospital-Blue Cross educational program, currently being carried out in districts throughout Ontario, a Peterborough radio station recently granted free radio time for interviews concerning the local hospitals, the Ontario Hospital Association, and the Blue Cross Plan. Subject material was designed to help listeners acquire a comprehensive understanding of their own hospitals—how they work with

other hospitals in the province to solve mutual problems and to provide the service of Blue Cross Plan for Hospital Care on behalf of the people.

* * * * *

Blue Shield is Catching Up

During 1949, for the first time, net enrolment growth of all Blue Shield Plans exceeded that of Blue Cross. As of December 31st, 1949, enrolment in 70 approved Medical Care Plans reached 14,267,243—a net gain of 3,899,779 participants. Over the same period, the 90 Blue Cross Plans enrolled 3,144,356 new members, bringing their total enrolment to 35,918,705. Payments to physicians by Blue Shield represented 79.67 per cent of income; payments for hospitalization by the Blue Cross amounted to 84.46 per cent of income.

* * * * *

Enrolment Statistics

More than 38,500,000 persons in the United States and Canada were enrolled in voluntary non-profit Blue Cross hospital plans on June 30, 1950, and it is expected that there will be more than 40,000,000 members by the end of the year. The enrolment represents 24 per cent of the population of the United States and 25 per cent of the population of the eight Canadian provinces served by Blue Cross.

The voluntary non-profit Blue Shield medical care plans enrolled more than a million persons during the second quarter of 1950, making this the largest enrolment period in the history of the medical plans.

* * * * *

The Ontario Hospital Association through Blue Cross has provided benefits averaging over one million dollars for each of the first six months of 1950.

* * * * *

As we go to press, it has been announced that the Blue Cross and P.S.I. Package Plan (Ontario), described on page 56 of our September issue, is now being offered to the general public.



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OCTOBER, 1950

97

With the Auxiliaries

Canmore Women Form Hospital Work Group

In Canmore, Alberta, a group of community-spirited women met recently with the object of organizing a committee to assist the Canmore Hospital. Their first project will be to make and repair the linens required at the hospital.

Auxiliary Plans for Opening of New Hospital

The Women's Auxiliary of St. Marys Memorial Hospital, St. Marys, Ont., will assist with the program for the official opening of the hospital. The ladies plan to have a shower of canned goods from the public, for the hospital kitchen, and

will have a display of babies' knitted wear along with other gifts.

Further, the auxiliary will supply a book cart for the wards. The treasurer's report showed a balance of \$586.75.

* * * * *

Tag Day Provides Linen for Hospital

The hospital aid at Gilbert Plains, Manitoba, recently held a tag day and realized the sum of \$185.26. This will be used to provide new linen for the Gilbert Plains Hospital.

* * * * *

Novel Idea Helps Guild

The ladies of the Seven Sisters Hospital Guild, Seven Sisters Falls, Man., have been serving luncheons to visiting parties this summer in aid of their hospital. A total of \$285 has been raised so far and additional luncheons will increase this amount. On these and other occasions, autographs for the hospital quilt project have been subscribed to the amount of \$31.88.

* * * * *

Auxiliary Receives Gift

A donation of \$200 will be used advantageously by the hospital guild of the new Whitemouth and District Hospital, Whitemouth, Manitoba. The members have decided to purchase an operating room lamp with the money which was a gift from their honorary president, Mrs. M. Smerchanski, of Winnipeg. Donations derived from a glass shower, held by the ladies, will also be presented to the hospital.

The Danger in Super-Hospitals

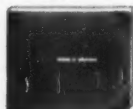
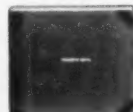
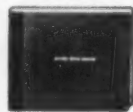
Hospitals can be too large, according to Dr. G. D. W. Cameron, Canada's Deputy Minister of Health. He recently told the Senate Committee on public health and welfare that the "huge super-hospital" is impractical in terms of national defence. "One direct hit and it is wiped out", he said, and also added that ultra-large hospitals were "beyond the comprehension or any intimate control of a superintendent".

Mix a little mystery with everything and the very mystery arouses veneration.

—Baltasar Gracian.

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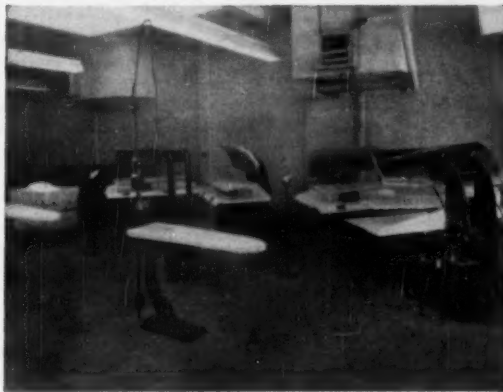
The laundry in this modern new hospital is a model in every respect. Their equipment is of the latest design, the floor plan is carefully thought out to eliminate all unnecessary steps. This combination of up-to-date equipment, latest laundry techniques and extremely workable floor plan layout is already producing high quality laundry work.

Of course, Golden XXX pure soap is the logical choice, and Golden XXX has been specified, as it has been for many years in the former Peterboro Civic Hospital.

Colgate congratulates the city of Peterboro, and especially all those citizens responsible for the erection of this modern new hospital.

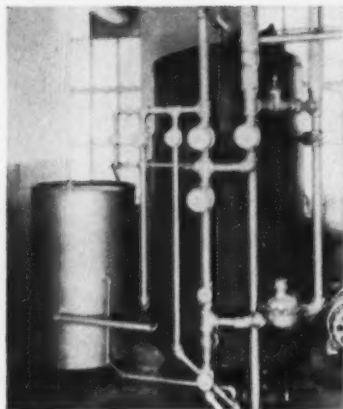
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COMPANY LIMITED
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Ground Covers

(Continued from page 52)

suckle, coralberry, *rosa multiflora*, and Morrow's honeysuckle. Harking back to the subject of weeds and their possible utilization, I have in mind a somewhat naturalistic residential area in the city where a number of very steep high slopes are thickly clothed with a quite pernicious weed about 12-18" in height. As it covers these most difficult slopes with a solid green mat where little else would grow and holds the steep bank from erosion, which would otherwise be a problem, it is definitely an asset rather than a pest. Whether it was planted on purpose years ago by some intelligent and far-seeing gardener or whether it has spread here of its own accord from elsewhere, I am not prepared to say. But the result is highly satisfactory in that it converts an otherwise steep unsightly embankment into a pleasant green hillside and requires absolutely no upkeep. To try to purchase plants to cover such a huge area would be well-nigh prohibitive. It spreads by underground runners and so will make its way into valuable plantings if given a chance. Nevertheless I can think of many a bare unsightly ravine lot where the natural growth has been disturbed and lost and where a common weed of this kind could be a veritable boon.

Lessening Maintenance

One of the main purposes of ground covers is to lessen maintenance and, with that in mind, the following questions might be given attention: Do you know a planting-bed where annuals struggle each year (with extremely poor results) to do what is expected of them? Why not discard the idea of having flowers here and fill the bed with periwinkle, pachysandra, lily-of-the-valley, violets, or euonymus? If desired, bulbs can be planted for early spring colour, when we crave it most, and when they are past why not be content with a simple green carpet which requires practically no care?

Do you spend hours keeping the ground under some shrub free of weeds? Why not underplant the shrub with a ground cover of any of the above, adding the spring bulbs also if desired? When the

shrubs leaf out they will tend to hide the dying foliage of the daffodils or tulips, which is an annual problem.

Is there a shady corner in your perennial border where flowers are always thin, poor, and late coming into bloom? How about discarding the flowers and concentrating on a ground cover of lily-of-the-valley, forget-me-nots, violets, Solomon's seal and ferns?

Is there a spot where you wish to discourage walking? If the area is covered with something more difficult to walk over, it is quite effective in discouraging traffic. A solid mass of *Euonymus vegetus*, periwinkle, or pachysandra, will frequently be effective. It is more in the nature of a psychological barrier but it often works. Or you may wish to keep passers-by from walking close up to, and peering curiously over, your front hedge into your garden. If a similar ground cover is planted there, extending six feet or more out from the hedge, the temptation is much less pressing.

Have you, perhaps, just a small pocket-handkerchief of a lawn between your house and the street where there is little necessity to walk? Or possibly there is a similar pocket below, or above, a wall or steps where one has to lug the lawn mover every week and can hardly find room to manipulate it when there? Perhaps you may have some narrow beds on your flagstone terrace along the house wall which you fill faithfully each year with annuals. You go away for the summer and when you return your petunias are gangly and thin and quite pathetic. Why not fill such beds with a solid mass of rich green shiny periwinkle or pachysandra which looks tidy and green almost all year? In the case of periwinkle there is even the asset of colour in spring when it produces bloom of a beautiful soft *periwinkle* blue. Also there are our evergreen ground covers such as the flat and spreading andorra, juniper, and tamarisk-leaved savin, suitable for such areas.

The possibilities for the use of ground covers are becoming more and more apparent as we strive for a reduction in maintenance. It may mean less colour in the garden but it also means more time to enjoy it. Unless gardening is a pet hobby

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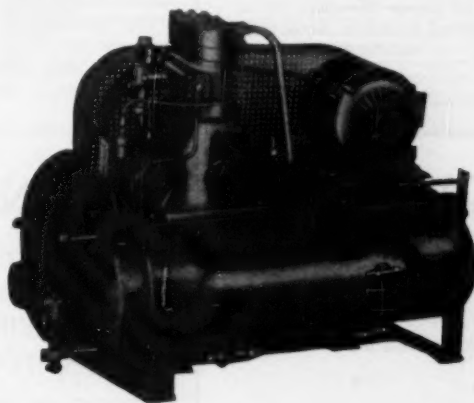
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and relaxation at the end of the day, few of us relish the idea of spending our precious leisure hours obliterating weeds, watering, mowing, and cultivating. A garden which can look after itself as much as possible is worth the sacrifice of some colour. Effective proof can be found in the use of ground cover plants in places where easy access is not important; or in the frank use of a good paving, such as flagstone or brick, where concentrated and continuous traffic (as under the gate and at the bottom of steps) wears out the grass and leaves ugly bare spots too hard for the most tenacious roots to penetrate.

Play a Simple Melody

(Concluded from page 64)

selector switch for choosing the channel and controlling the volume is conveniently placed for the anaesthetist to adjust. In the operating room, where apparatus must be kept at a minimum, the musical outlets include a wall outlet, a reel of extension cable, a volume-control box,

and a storage box for the two sets of earphones.

Although the use of "musical surgery" is not commonplace in most hospitals at the present moment, it may become more popular as the years go by. The day may come when you will ask your patients if they prefer Bach or Boogie. Therefore, for all surgical patients and anaesthetists one can only predict—"happy listening"!

New Mental Clinic for Sudbury, Ont.

The federal government has approved a mental health clinic for Sudbury and the Sudbury Board of Health have appointed Dr. Tom Dixon as psychiatrist. Expenses for the clinic will be borne entirely by the Dominion government, with payments being administered through the Ontario Department of Health.

Prevention of mental health disorders will be the general purpose of the clinic, which will have a staff of one psychiatrist, one psychologist, a nurse and a stenographer.

Tentatively, it is planned to house the clinic in the new Sudbury General Hospital, now nearing completion.

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THE *Stevens* COMPANIES

TORONTO WINNIPEG CALGARY VANCOUVER

A.H.A. Convention

(Concluded from page 44)

\$5 to \$7.50 and from \$25 a year to \$3.75 a month or \$45 a year. This amendment was adopted with a minimum of opposition.

Off and On the Boardwalk

If not exactly constituting a fashion parade, the many Canadians at Atlantic City certainly displayed an admirable enthusiasm and interest. They represented every corner of Canada, ranging from Ralph Gale of Saint John to George Masters of Victoria, from Sister M. Camillus of Prince Albert to Harry F. Garwood of Niagara Falls. A large contingent took part in the ceremonies of the A.C.H.A. convocation topped off by Dr. A. C. McGuggan, who was advanced to fellowship. (See page 36).

"Pots 'N Pans 'N Potatoes"

A busy, stimulating program of meetings was carried on during the convention by the energetic representatives of hospital auxiliaries. The role of an auxiliary as an interpreter of the hospital to the com-

munity was stressed, while ideas for money-raising were related and exchanged. At a luncheon, James A. Hamilton, a former president of the A.H.A., spoke on "Pots 'N Pans 'N Potatoes", outlining various programs that auxiliaries could follow.

Exhibits

The largest number of exhibits on record were enjoyed by delegates to this year's convention, although real exercise was involved in covering the display area. There were some 578 booths, with 33 scientific exhibitors, and 311 representatives of hospital industry. One striking and timely exhibit pictured a medical aid station, patterned after those set up in Korea. The replica, complete with tent, stretchers, and "patients", was manned by Army personnel.

Officers

President: Dr. Charles F. Wilinsky, Boston.

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Second Vice-president: Leo. G. Schmelzer, Washington, D.C.

Third Vice-President: W. E. Arnold, Jacksonville, Fla.

Treasurer: Dr. A. C. Bachmeyer, Chicago.

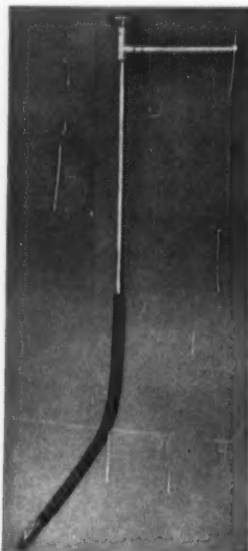
To the Board of Trustees: Miriam Curtis, Syracuse, N.Y.; Ray Amberg, Minneapolis; Dr. Lucius R. Wilson, Philadelphia.

Intern Placement

(Concluded from page 62)

best appointment open to him in accordance with his expressed preference.

8. Re Approved Hospitals: Medical students should note that, for those individuals who desire certification or fellowship in the Royal College of Physicians and Surgeons of Canada, or who desire to practice in the U.S.A. and write the examinations of the National Board of Medical Examiners, these two bodies require candidates to have interned in hospitals approved either by the Canadian Medical Association or American Medical Association.



FLEXIBLE GASTROSCOPE

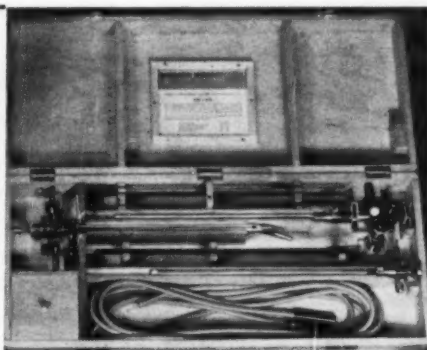
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L'Organisation Hospitalière

(Suite de page 92)

cette sphère particulière, le progrès, nous le savons, est continu. On propose, en prévision de l'avenir, de placer le département de radiologie entre des services qu'il ne serait pas trop difficile ou trop dispendieux de transporter ailleurs, au cas où une expansion s'imposerait.

Je ne saurais terminer sans mentionner un progrès qu'aucun d'entre nous n'est heureux de constater, je veux dire l'élévation du coût de presque toute ce qui a rapport à la construction et à l'exploitation des hôpitaux.

Le coût élevé des soins hospitaliers oblige tous les intéressés à surveiller de près leurs établissements, afin de les rendre plus efficaces. C'est vrai surtout en ce qui regarde la liste de paie des membres du personnel, qui retient 60 p. 100 de chaque dollar.

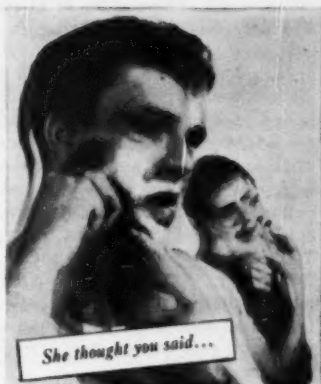
Les difficultés commencent quand l'architecte et le surintendant de l'hôpital étudient leurs plans, car ils doivent fournir un édifice qui répondra sous tous les rapports à ce qu'on attend de lui; mais ils doivent surtout empêcher que ceux qui dirigent l'hôpital et soignent les malades gaspillent leur énergie.

On doit étudier les divers économiseurs de travail que l'on a trouvés au cours des dernières années, et comparer leur coût à l'économie que leur exploitation réalisera. Il s'agit de comparer le coût initial à celui du maintien ou de l'exploitation, car on ne peut les séparer l'un de l'autre.

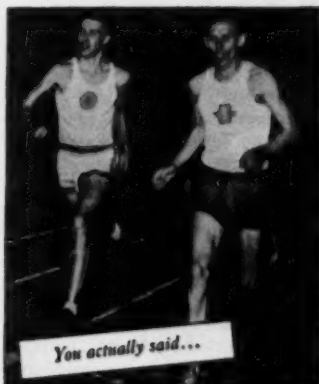
Avant de conclure, je tiens à rendre un hommage sincère aux hommes et aux femmes des hôpitaux confessionnels de tout le pays, qui consacrent leur vie à la noble cause de l'allègement des souffrances humaines. Ils savent les grands progrès que les soins médicaux ont réalisés, comme le prouvent les nombreux et magnifiques hôpitaux qu'ils ont édifiés, mais ils n'ont pas oublié non plus ce que représentent les bons soins donnés au chevet des malades. C'est là que l'on voit le dévouement aller de pair avec le progrès.

Surgery has been made safe for the patient: we must now make the patient safe for surgery.

—Lord Moynihan.



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With an Indian Health Nurse in Saskatchewan's Northland

Travelling 2,000 miles in the past year by canoe, dog team, and snowmobile through the wild, hazardous tracts of the far north-land, and 3,000 more by air, is the record of the matron at the Indian Health Services Hospital and Nursing Station at Lac la Ronge in northern Saskatchewan. Matron Marjorie Talmay serves an area 200 miles north from the village and 100 miles east and west. The hospital, opened in February, 1949, is a two-storey frame building which was formerly a missionary's residence. Previously, the Indians and white people of the district had to go to Prince Albert, hundreds of miles to the south, to obtain medical care, or do without. The main services called for are maternity care for native mothers and first aid for frost bite, axe cuts, blood poisoning, and minor accidents. Treatments given the 1,563 patients cared for in the dispensary included removing fish hooks from the cheeks of careless anglers and suturing a split ear

so successfully that no scar remains today. There were 36 births and only one death. During this first year of operation an epidemic of measles hit the settlement and all but two of the homes were affected. Several of the 99 cases attended by the matron were complicated by pneumonia; but there were no deaths and no help was required from outside, although the epidemic lasted 2½ months. Nurse Talmay also visited the local school four times, assisted in a comprehensive inoculation program, and instructed mothers in pre-natal and post-natal care and in standards of hygienic living.

Just after Christmas, Miss Talmay fractured her toe and ankle bone. She went to Prince Albert for treatment but was back in two days to carry on, cast and all. A graduate of Toronto General Hospital in 1941, this pioneer-spirited matron, except for three months spent at Fort Qu'Appelle, had only city experience to prepare her for this life of adventure and resourcefulness in the far north.

The Medical Staff

(Concluded from page 84)

staff under them. As an example, what would you do if one of your interns reported to you that a case was not being treated properly? I think that the solution would be for you to ask the head of staff to see this case and give you his opinion. If he considers that the case is not being treated properly, he should contact the attending physician and advise him of his feelings in the matter. The attending physician must be prepared to have a consultation on the case and if he is not prepared to do so, the superintendent should ask him to remove the patient from the hospital. If the heads of staff assume this responsibility, they can assist you greatly with the proper management of medical organization. Any disputes in regard to the proper handling of a case should be referred to the executive committee. This committee being a large group can readily take executive action and if their wishes are not carried out, the matter should then be referred to the hospital board for action.

(To be concluded in November)

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Tips to Hospital Patients and Visitors

The *Whig-Standard*, Kingston, Ont., recently invited leading hospital administrators to give some advice to patients and visitors who may find themselves for the first time* in the unfamiliar surroundings of a hospital. Dr. G. W. Peacock, assistant superintendent medical of the Kingston General Hospital, offered the following suggestions.

The prospective patient should select the hospital according to his doctor's preference and be prepared to follow his counsel in all matters concerning his welfare. If the patient insists upon his own way, he should stay at home and free a hospital bed for someone who really needs it.

New patients should plan to be admitted into the hospital before 4 p.m. It is important that they be properly settled for the night and that laboratory and other tests be started on time. While to many the intern is only someone who asks tedious questions, to the hospital and the doctors he plays a

very important role in investigating case histories. It is the responsibility of the patient to provide him with all the pertinent facts for a complete history.

Once he is in the hospital, the patient should relax and let the staff do the worrying. He should not hesitate to ask legitimate questions when something is bothering him, or point out changes or new symptoms in his condition. However, he should not ply the staff with unnecessary questions or attempt to direct treatment. He should bear in mind that there is a nursing shortage and keep his patience and sense of humour.

Upon entering a hospital, the patient should inquire and adhere to the institution's policies and procedures and request his visitors to respect them, too. Objectionable though these regulations may appear at first, they are based upon years of experience and represent what is best for the patient.

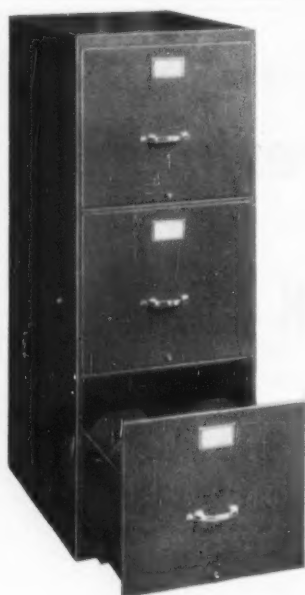
Not only the patient but the visitor, too, should observe certain rules of conduct while in a hospital.

The following list of admonishments should be carefully perused.

Do Not:

- Break the visiting hour rule;
- Visit for too long a period;
- Bring small children;
- Be loud or noisy;
- Smoke in a semi-private room;
- Cough on or near the patient; in his condition, the patient is susceptible to colds and other infections;
- Sit on the bed but sit where the patient can easily see you;
- Be an amateur physician;
- Be morbid and tell him what has happened to "Joe" who had the same symptoms;
- Pity the patient but show genuine sympathy;
- Appear worried or concerned although you may feel it—hope is a natural medicine but fear is a contagious disease;
- Tell the patient your own troubles;
- Visit if you cannot observe these rules.

The visitor should show genuine interest and sincere optimism in the presence of a patient. Arti-



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ficiality is easily spotted and can be most distressing. Well-meaning but ill-advised visitors may often do more harm than good; therefore, mark well these simple rules and you will help the patient, the doctor, and the hospital.

A Diet Kitchen

(Concluded from page 42)

on food preparation. Included in her work is the planning of the menu, which is patterned as much as possible on the "house menu"; she is taught always to bear in mind Canada's Food Rules and is coached on selecting foods with an eye to palatability, especially contrasts in texture and colour, as well as the necessary adjustments which must be made for the various diets. Diets are individually written on forms and the intermediate nurse summarizes these for correct preparation and portioning. The senior nurse visits patients with the dietitian, where she examines patients' charts and here again absorbs more information on diet in relation to disease.

Coming Conventions

- Oct. 16-21—Western Canada Institute for Administrators and Trustees, Fort Garry Hotel, Winnipeg.
- Oct. 21—Manitoba Hospital Association, Fort Garry Hotel, Winnipeg.
- Oct. 21-23—B.C. Conference of Catholic Hospitals, St. Paul's Hospital, Vancouver.
- Oct. 23-27—Clinical Congress of American College of Surgeons, Statler and Copley Plaza Hotels, Boston.
- Oct. 23-Nov. 3—A.H.A. Personnel Management Institute, Cornell University, Ithaca, N.Y.
- Oct. 24-27—British Columbia Hospitals' Association, Vancouver Hotel, Vancouver.
- Oct. 25-26—B.C. Association of Hospital Auxiliaries, Vancouver Hotel, Vancouver.
- Oct. 26-27—Associated Auxiliaries of the Hospitals of Alberta, Palliser Hotel, Calgary.
- Oct. 26-28—Associated Hospitals of Alberta, Palliser Hotel, Calgary.
- Oct. 28-30—Canadian Association of Occupational Therapy, Royal York Hotel, Toronto.
- Oct. 30-Nov. 1—Ontario Hospital Association, Royal York Hotel, Toronto.
- Oct. 30-Nov. 1—Women's Hospital Aids Association, Ontario, Royal York, Toronto.
- Nov. 2-3—Ontario Conference of the Catholic Hospital Association, Toronto.
- Nov. 5-6-7—Canadian Association of Occupational Therapy, Chateau Laurier, Ottawa.

In view of the fact that the student nurses express satisfaction with what they have learned, the special diet patients are individually attended to, the dietitian is enabled to extend her efforts to other sections

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REFERENCES:

- "Polyethylene, a New Synthetic Plastic for Use in Surgery", F. D. Ingraham, M.D., E. Alexander, Jr., M.D., D. D. Matson, M.D.; J.A.M.A., Sept. 13, 1947.
- "Synthetic Plastic Materials in Surgery", F. D. Ingraham, M.D., E. Alexander, Jr., M.D., D. D. Matson, M.D.; New England J. Med., March 6 and 13, 1947.

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Story of the Award
(Concluded from page 39)

of Dr. Stephens will be recalled as well as that of the recipient of the award. In honouring one, the other, too, is honoured.

The award was established by the Canadian Hospital Council in 1949 when it was presented to Dr. A. K. Haywood of Vancouver. Nominations may be made by any interested person or group and are directed to the Executive Secretary. The selection is made by the Executive Committee of the Canadian Hospital Council on the basis of noteworthy service in the realm of hospital administration with emphasis on personal efforts to advance the efficiency of Canadian hospitals, to develop regional and national organizations and to foster social progress, with particular recognition of consistent service and leadership over the years.

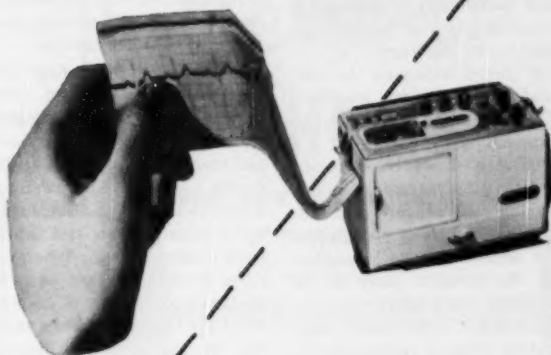
In Praise of Voluntary Service

Addressing the annual meeting of the Greater Vancouver Health League recently, the Hon. Paul Martin reviewed the achievements of the national health program since its inception two years ago. During this period, ten provinces have received aid to re-survey their entire public health facilities; more than 2,000 health workers have been employed and 1,500 received training; federal hospital construction grants have helped to extend hospital accommodation by 21,000 beds; and grants totalling \$38,000,000 have been allocated for more than 3,000 provincial health projects.

Commending voluntary organizations and medical and allied professions for their valuable contributions to the health of the nation, Mr. Martin referred to the "dynamic humanitarian quality in voluntary service that cannot be legislated or paid for. We must never," he pointed out, "let the magnitude of government efforts overshadow what is done by the voluntary health agencies."

There is no wealth but Life. Life, including all its powers of love, of joy, and of admiration. — John Ruskin.

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Stratford

(Concluded from page 34)

after the water is distilled, it is stored in sterile bottles in both the central supply room and the sterilizing rooms off the operating suites, thus eliminating the need for mechanical water sterilizers. The supply room being centrally located, dumb waiters can carry sterilized water, instruments, and supplies up to the various work rooms.

Unfortunately, however, since the main receiving entrance to the hospital and the general store room are located at the far end of the kitchen, it would appear that all supplies entering the hospital have to be taken through the kitchen.

The pharmacy department, with its own store room, is adjacent to the supply room, and the remainder of the basement is occupied by the housekeeper's room, storage space, and mechanical equipment. Such equipment as the air conditioning unit, exhaust fans, and elevator motor, occupy the space in the pent-house sixth and seventh floors.

Tunnels lead from the basement to the old hospital, the nurses' resi-

dence, and the new power house. In the latter, which has been in operation since April, 1949, are housed the boiler rooms, and the laundry. The hospital has a forced hot water heating system with convector radiators, the temperature being governed by an outside thermostat.

Construction throughout the hospital has been planned with the constant objective of providing quiet for the patient. All noisy machinery has been placed on the seventh floor or the basement. All corridors and service on patient floors have acoustic plaster ceilings and the former have linoleum floors. Wherever possible, workrooms have been located on the opposite side of the corridor from the bedrooms; when this could not be managed, partitions faced with glass sound-insulating material have been used. Rubber-tipped bumpers have been used also on the beds and movable equipment. The comfort of the patient is furthered by the use of louvered screening which eliminates about three-quarters of the glare from the sky, with scarcely any diminution in the amount of light admitted.

Landscaping of the grounds is to be undertaken only gradually. The area framing the entrance is being terraced and further embellished by strategically arranged flower beds but, for the time being, timothy grass will provide the ground cover in the surrounding acreage.

This fine new hospital, together with the rejuvenated old hospital in its new phase of service, should provide Stratford with adequate and satisfying hospital service for many years to come.

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**Hebrew Medical Journal
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The appearance of Volume 1, 1950, of *The Hebrew Medical Journal* (*Hafoté Haveri*) inaugurates the 23rd year of its publication under the editorship of Moses Einhorn, M.D.

Written in Hebrew with English summaries, the Journal is an influence in the improvement of health in the new State of Israel, a service to the newly established Hebrew University-Hadassah Medical School, and a contribution to the development of Hebrew medical literature.

In the current number appear articles on "Orthopaedic Problems in Israel", "Fighting Deafness in Israel", and "Kupat Holim—The Labour Health Service in Israel". The historical sections contain essays on "Pathological Symptoms Caused by the Famine during the Siege of Jerusalem by Nebuchadnezzar, King of Babylon" and "Ascites—A 10th Century Manuscript".

More detailed information may be obtained from *The Hebrew*

Medical Journal, 983 Park Avenue, New York 28, N.Y.

Wielding the Spade

When I go into my garden with a spade and dig a bed, I feel such an exhilaration and health that I discover that I have been defrauding myself all this time in letting others do for me what I should have done with my own hands.

—R. W. Emerson.

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The new Hospital for Sick Children, Toronto (630 beds) has an opening for a Registered Record Librarian in a senior position. Staff of eight assistants. University teaching hospital in Paediatrics and Children's Surgery. Standard nomenclature. Please address applications or enquiries to Joseph H. W. Bower, Superintendent, The Hospital for Sick Children, 67 College St., Toronto.

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The Kingston General Hospital (Medical Teaching Hospital for Queen's Medical School) has an opening for a registered Record Librarian in the Senior position. The authorized staff consists of three registered librarians and three assistants, including medical stenographer.

In addition to the Senior opening, the present staff is being enlarged for one assistant. The present Librarian in charge is leaving Kingston for reasons beyond her control, but will be available to work with the new officials for several weeks.

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